

JUNE 1, 1953

MODERN MEDICINE

The Journal of Diagnosis and Treatment



Dr. Albert B. Sabin
See page 9

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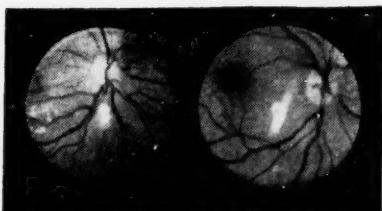
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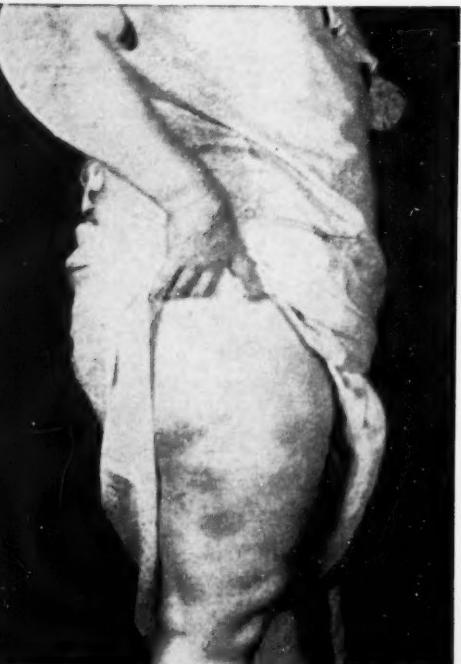
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1. Krantz, J.C., Jr. & Carr, C.J.: The Pharmacological Principles of Medical Practice, The Williams & Wilkins Co., Baltimore, Md., 1951, p. 836.



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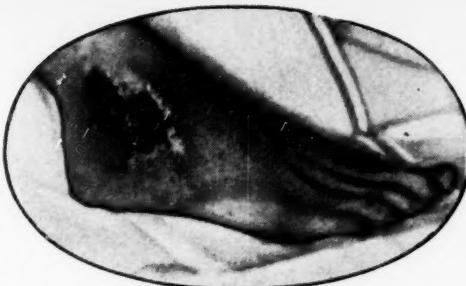
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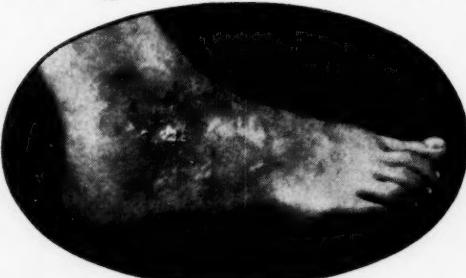
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1953

Modern Medicine
Vol. 21, No. 11

THE MAN ON THE COVER is Dr. Albert B. Sabin of Cincinnati, virologist and research pediatrician. In 1941, the American Academy of Pediatrics granted Dr. Sabin the E. Mead Johnson Award for research on virus diseases of the nervous system. Professor of Research Pediatrics at the University of Cincinnati since 1946, Dr. Sabin is a fellow of the American Association for the Advancement of Science which, in 1939, accorded him the Theobald Smith Award in Medical Sciences. A member of numerous scientific organizations, including the Society of American Bacteriologists and the Cuban Society of Microbiology, Dr. Sabin has contributed over 100 articles to scientific journals. The report on page 106, "Congenital Toxoplasmosis," appeared originally in the *Journal of the American Medical Association*.



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LETTER FROM THE EDITORS

Dear Reader:

Carefully calculated endeavors sometimes produce effects just opposite to those intended.

In editing *Modern Medicine* we go to great lengths to save the doctor's time.

First the periodical literature is carefully screened. The editors and consultants select for review only articles that promise to have wide interest and great utility. Then the writing of the reports, the typography, the layout, and the illustrations are carefully planned to give the essential points easily and quickly to even the casual reader. And to what end? To save the doctor's time.

Are we successful in this effort? One reader, at least, says "No." He writes:

I find *Modern Medicine* to be an excellent method of making a rapid survey of medical literature. I would NOT call it a timesaver because the material presented often leads to further reading. I would rather call *Modern Medicine* a "thought-channeler" as it tends to make me SPEND MORE TIME with the professional literature than I otherwise would during a busy day.

It would seem that our timesaving efforts have failed this reader. The failure is more apparent than real. *Modern Medicine* has stimulated his thinking and made it easier for him to get more information. The larger interest is served, for doctor and data are brought together. Ergo, success, for *Modern Medicine* is dedicated to the proposition that the informed physician is the best physician.

The Editors



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Correspondence

Communications from the readers of MODERN MEDICINE are always welcome. Address communications to The Editors of MODERN MEDICINE, 84 South 10th St., Minneapolis 3, Minn.

Intravenous Urograms

TO THE EDITORS: Had I not seen your abstract of Dr. Reed Nesbit's article on hydronephrosis (*Modern Medicine*, Mar. 15, 1953, p. 116), I would probably have missed this important contribution. After reading your abstract I studied the original article in the library of the Philadelphia College of Physicians.

I would like to comment briefly on one subject discussed in this paper—intravenous urograms done while patients are having pain from ureteral obstruction. My interest in this particular procedure goes back to 1940 (*J. Urol.* 48:622-627, 1942).

Atypically, renal colic may cause pain only in the right lower abdomen and thus create suspicion of appendicitis when the patient is in the receiving ward. An immediate intravenous urogram may quickly establish the correct diagnosis.

Dr. Nesbit refers to nonvisualization of the affected kidney. My experience has been that distention of the ureter will often become apparent on films made several hours after the injection.

Nonopaque calculi may cause intermittent painful hydronephrosis and yet give normal findings on films when intravenous urography

is carried out during pain-free periods.

JAMES F. MC CAHEY, M.D.
Philadelphia

Complete GG Picture

TO THE EDITORS: I have appreciated receiving *Modern Medicine* for a number of years. I have always found the articles very concise and to the point.

This was again borne out when I read your March 15, 1953 issue. As I am interested in the control of communicable diseases, I have numerous inquiries from physicians regarding the use of gamma globulin in measles, infectious hepatitis, and poliomyelitis. You presented a very complete picture of gamma globulin in your Special Exhibit (p. 102).

I have reread this article many times and have loaned it to my colleagues here at the State Board of Health who do not receive your journal. As a result, my copy is becoming quite worn. I would appreciate very much having another copy.

A. L. MARSHALL, JR., M.D.
Indianapolis

¶ A new copy to replace the well-worn one has been sent to Dr. Marshall.—Ed.



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(1) Crumpton, C. W. et al.: Abstract, Society for Pharm. & Exper. Therap., September 8-10, 1952, J. Pharm. & Exper. Therap., 106:378, December, 1952. (2) Currens, J. H. et al.: Abstract, Program, American Heart Assn., April 18-19, 1952. (3) Meilman, E., and Kraver, O.: Circulation, 6:212, August, 1952. (4) Hoobler, S. W. et al.: Ann. Internal Med., 37:465, September, 1952. (5) Smirk, F. H., and Chapman, O. W.: Am. Heart J., 43:586, 1952. (6) Nash, H. A., and Brooker, R. M.: Abstracts of Papers, 122nd Meeting Am. Chem. Soc. (September, 1952) p. 231. (7) Nash, H. A., and Brooker, R. M.: J. Am. Chem. Soc. (in Press).

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Autonomic Drug Series Fine

► TO THE EDITORS: I would deeply appreciate 2 reprints of the fine Symposium appearing in the March 15, 1953 edition of *Modern Medicine* (p. 127). The Symposium included the following articles, all of which I desire: "Autonomic Drugs: An Introduction," by John C. Krantz, Jr.; "The Autonomic Nervous System and Hypertension," by Arthur Grollman; "The Sympathomimetic Agents," by Raymond P. Ahlquist; and "Adrenergic Blockade," by Fredrick F. Yonkman.

JOSEPH D. KARRAS, M.D.
Brookline, Mass.

► TO THE EDITORS: I should very much appreciate a reprint of Dr. Ahlquist's article, "The Sympathomimetic Agents" (*Modern Medicine*, Mar. 15, 1953, p. 134). It is one of the most complete articles I have been privileged to read and I shall be most interested in re-reading it.

JOHN R. LINCOLN, M.D.
Portland, Me.

► TO THE EDITORS: I would greatly appreciate reprints of your Symposium on Autonomic Drugs.

Your magazine is becoming more valuable every edition.

F. P. ANSBRO, M.D.
Brooklyn

► Requests for reprints should be addressed to the author of the article or articles desired. Addresses are:

Arthur Grollman, M.D.
Southwestern Medical School, University of
Texas
Dallas, Tex.

Raymond P. Ahlquist, M.D.
School of Medicine, University of Georgia
Augusta, Ga.

Fredrick F. Yonkman, M.D.
Ciba Pharmaceutical Products, Inc.
Summit, N. J.

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full
therapeutic
dosage
of aminophylline
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Each tablet contains:

Aminophylline 5.0 gr.
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Cardalin-Phen contains, in addition, 1/4 gr. of phenobarbital for sedation.

Cardalin and Cardalin-Phen tablets are best tolerated after meals and preferably administered with one-half glassful of milk.

Supplied: Bottles of 100, 500, 1000.

Cardalin and Cardalin-Phen contain 5 grains of Aminophylline per tablet...the highest concentration supplied for Oral Administration. Two protective factors (Aluminum Hydroxide and Ethyl Aminobenzoate) counteract the local gastric irritation so common to oral aminophylline therapy. Prolonged treatment at high dosage levels can be accomplished with Cardalin and Cardalin-Phen, as demonstrated by extensive clinical studies.

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CASE REPORT

"M. D., female, aged 48, had a posterior gastrojejunostomy 14 years ago for duodenal ulcer. The patient was fairly well until nine months ago when severe, intractable pains occurred. She was hospitalized and a subtotal gastrectomy was done.

"She remained well for only a few months and was referred to us because of recurrence of very severe pain and marked

*Trademark of G. D. Searle & Co.

Fig. 2: In ten weeks "the ulcer niche was no longer in evidence roentgenologically or gastroscopically."



Fig. 1: "Roentgen examination . . . revealed the ulcer to be very much in evidence."



weight loss. Roentgen study revealed a fairly large ulcer niche on the gastric side of the anastomosis.

"The patient had been on various types of antacids and sedatives without relief from pain. She was given 60 mg. of Pro-Banthine q.i.d. and within 72 hours was able to sleep through the night for the first time in weeks.

"At the end of two weeks of such treatment the patient had absolutely no pain and felt that she had been 'cured.' Roentgen examination at this time revealed the ulcer to be very much in evidence (Fig. 1). Much persuasion was necessary to make the patient realize the importance of maintaining her diet and therapy.

"Ten weeks of controlled regulation was necessary before we were satisfied that the ulcer niche was no longer in evidence roentgenologically or gastroscopically (Fig. 2).

"She has been maintained on 30 mg. of Pro-Banthine for almost five months with no recurrence of symptoms."

Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, to be published.

Pro-Banthine (*brand of propantheline bromide*), the new, improved anticholinergic agent, is more potent and, consequently, a smaller dosage is required and side effects are greatly reduced or absent.

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26

FAST!
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Poliomyelitis Transmission

TO THE EDITORS: Although I have already published a few books and have acquired immunity against the desire to see my name in print, I wish to accept your suggestion (*Modern Medicine*, Feb. 15, 1953, p. 16) and write you.

I regret that you reprinted the misleading article of Drs. Morris Greenberg and Harold Abramson on inoculations (p. 102).

When I was in Rome, I observed 2 cases of poliomyelitis after prophylactic or therapeutic injections in children. There seems to be evidence that the disease may be transmitted by syringes and needles which have not been autoclaved for at least one-half hour.

In all cases of vaccination and of immunization, those measures can be recommended which have proved useful for the eradication of inoculation hepatitis, that is, autoclaving of the equipment and the use of individual syringes and needles.

A decrease of poliomyelitis cases as a result of these precautions would prove that we have to consider syringes an important factor in the transmission of poliomyelitis.

ALEXANDER LENARD, M.D.
São Paulo, Brazil

Red Cross Support

TO THE EDITORS: Thank you for the support you are giving the Red Cross through *Modern Medicine*. We feel sure that it will aid materially in our achieving the campaign goal this year.

WALLACE E. HUTTON
American National Red Cross
Washington, D. C.

IN ANY ALLERGY

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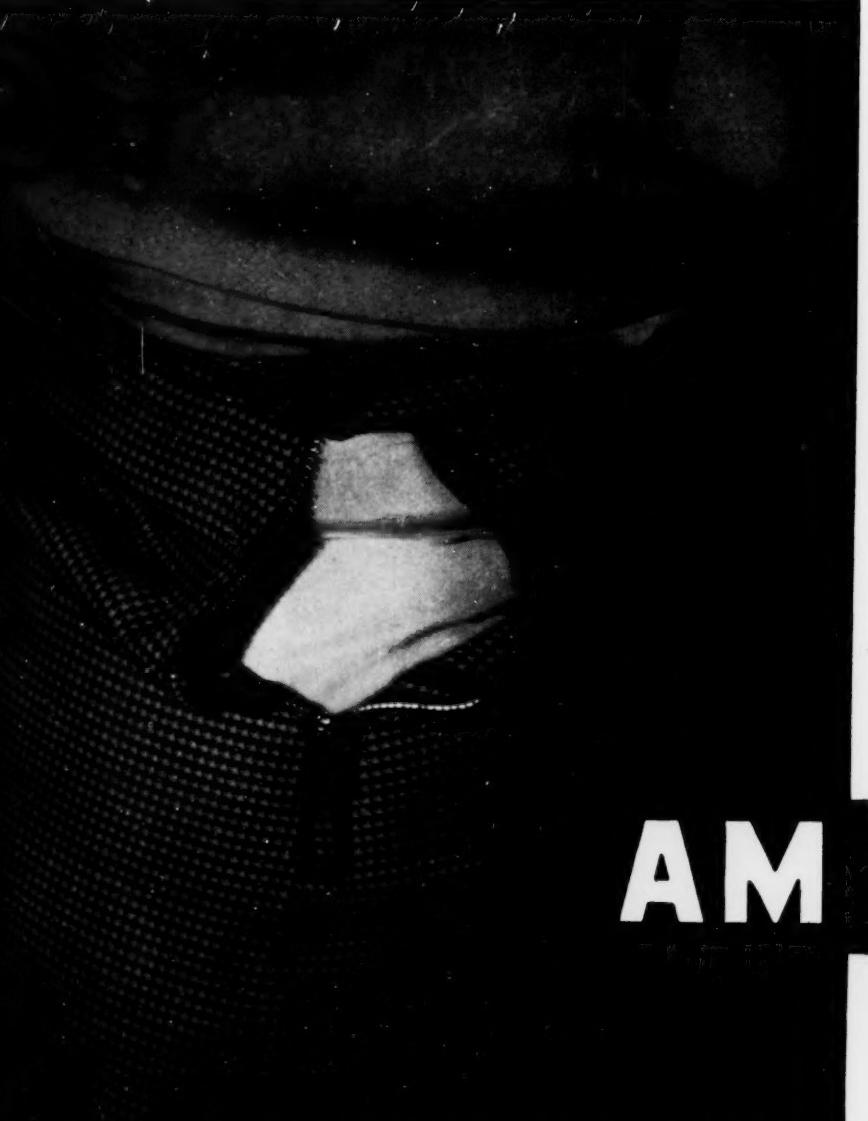
Mild symptoms: 1 pulvule every twelve hours.

Moderate symptoms: 1 pulvule every eight hours.

Severe symptoms: 2 pulvules every eight hours.

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"The treatment of obesity by diet, a system of controlled starvation, leaves the medical attendant with an obligation to maintain mineral balance as well as to avoid avitaminosis. The importance of 'trace minerals' ...must be considered in this connection."¹

AMPLUS not only helps maintain vitamin and mineral balance, but also avoids the gap between good intentions and cooperation with dextro-Amphetamine Sulfate.

Each capsule contains:



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Copper	1 mg.
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Thiamine Hydrochloride	2 mg.
Riboflavin	2 mg.
Pyridoxine Hydrochloride	0.5 mg.
Niacinamide	20 mg.
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¹Vernon, S.: *Nutritional Deficiency, Clin. Med., Oct., 1950, p. 187*

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SEPTISOL is a concentrate; one gallon makes two gallons of "use" solution.

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Abuse of Thyroid Extract

TO THE EDITORS: Regarding "Use and Abuse of Thyroid Extract" by Dr. Martin Perlmutter (*Modern Medicine*, Apr. 1, 1953, p. 66), I would like to add a note.

A common abuse of thyroid extract is seen frequently by the psychiatrist. This substance is prescribed to relieve the symptoms of neurasthenia or depression such as fatigue, lack of energy, lassitude, slowing-down, disinterest, poor appetite, and, in some cases, nervousness. In such cases the basal metabolic rate may or may not be in the lower limits of normal range.

The routine use of thyroid extract in these problems is not only of no value but is definitely contraindicated for a number of reasons, not the least of which are the toxic side effects which complicate the emotional problem.

M. BOVERMAN, M.D.

Sacramento

Aid in Teaching

TO THE EDITORS: I have been receiving your excellent journal and find its over-all review of pertinent contributions to medicine of special value in teaching. I was especially impressed with your Symposium on Trauma (*Modern Medicine*, Sept. 1, 1952, p. 65).

I should like to know if extra copies of this particular number are available, and if so, I should like to have sufficient for the members of the graduating class this year. I realize that this is an unusual request, but if it is at all possible to grant, it would certainly be greatly appreciated.

JOHN ARMES GIUS, M.D.

Iowa City

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—Upon presentation of the patient for treatment, 1 cc. of GRAVIDOX Solution *Lederle*, containing 50 mg. of pyridoxine HCl (B₆) and 50 mg. of thiamine HCl (B₁) may appropriately be given two or three times weekly. For maintenance of dosage, GRAVIDOX Tablets *Lederle*, thiamine HCl (B₁) 20 mg. and pyridoxine HCl (B₆) 20 mg., may be given orally in a total daily dosage of 5 to 12 tablets, at times when vomiting is least likely to occur.

Literature available to the physician should be consulted.

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No. 1

MODERN MEDICINE
84 South 10th St.
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"An infarct has nothing to do with gas on the stomach."

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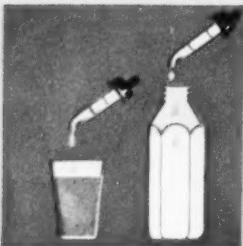
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	Vitamin A	Vitamin D	Ascorbic Acid	Thiamine	Riboflavin	Niacinamide
POLY-VI-SOL Each 0.6 cc. supplies	5000 Units	1000 Units	50 mg	1 mg	0.8 mg	6 mg
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Questions & Answers

All questions received will be answered by letter directed to the petitioner; questions chosen for publication will appear with the physician's name deleted. Address all inquiries to the Editorial Department, MODERN MEDICINE, 84 South Tenth Street, Minneapolis 3, Minnesota.

QUESTION: What effect does cigarette smoking have on a pregnant woman? Is lactation affected?

M.D., Michigan

ANSWER: By Consultant in Obstetrics. Cigaret smoking in moderation has no apparent effect on the pregnant woman or on lactation after delivery. Most obstetricians limit the number of cigarettes to 6 to 10 daily. Of course, the usual medical contraindications to smoking should be observed for patients with cardiovascular disease, chronic respiratory infections, asthma, and so forth.

QUESTION: What method do you recommend for sterilizing glass syringes?

M.D., Illinois

ANSWER: By Consultant in Laboratory Technic. Glass syringes are best sterilized by using dry heat. Exposure to 160° C. for one hour is ideal. An alternate technic is to subject the syringes to dry heat at 121° C. in the chamber of a dressing sterilizer in which steam pressure is maintained in the jacket overnight. Small syringes can be packaged in test tubes covered with cellophane or paper flaskhoods.

If saturated steam must be used, corrosion can be kept at a mini-

mum by thoroughly preheating the glassware. The syringes should be disassembled to expose the barrel and plunger to the steam and to avoid bursting fractures.

QUESTION: What treatment do you advise for rubella encephalitis?

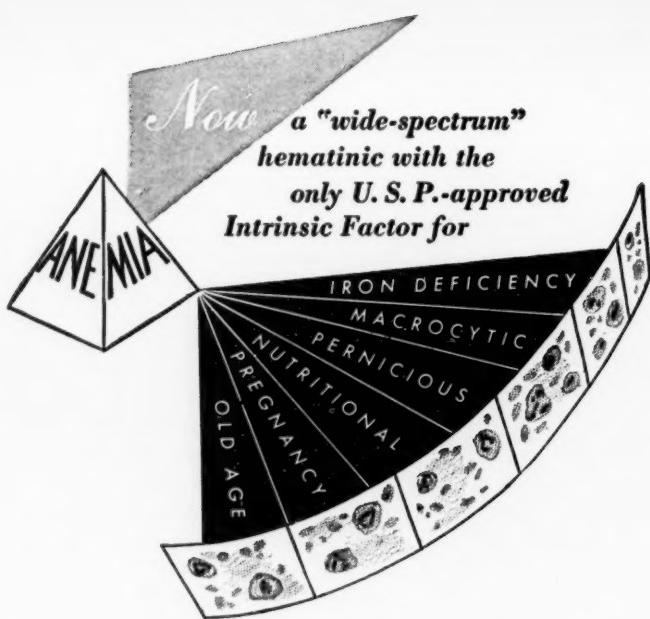
M.D., Ohio

ANSWER: By Consultant in Neurology. No specific treatment is known for this type of cerebral involvement. In adults, this condition usually clears without any after effects. In children, the prognosis must be a little more guarded depending upon the severity of the illness. From a therapeutic standpoint, symptomatic treatment is all that is necessary.

QUESTION: Does the viewing of television cause eyestrain?

M.D., Kentucky

ANSWER: By Consultant in Ophthalmology. With a good set, adequate correction of any refractive error, and proper conditions of illumination, television should not cause eyestrain. I do not believe that viewing of television under these circumstances could possibly cause permanent damage to the eyes.



BINAEMON®

may be prescribed for any form of anemia—hypochromic, microcytic, macrocytic, normocytic, or pernicious—for it supplies in each easy-to-take tablet five ingredients needed for adequate treatment of any and all of these blood diseases. Binaemon contains Bifactor® (Vitamin B₁₂ with Intrinsic Factor Concentrate), 1/9 U.S.P. unit; folic acid, 0.8 mg; vitamin C, 50 mg; ferrous sulfate, 133 mg; and liver concentrate, 100 mg. Because Binaemon supplies intrinsic factor, it provides a safe hematinic, for it assures B₁₂ absorption and prevents folic acid from masking the symptoms of incipient pernicious anemia. Prescribe Binaemon for all your anemic patients.

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WHAT DOES **pain** SMELL LIKE, DOCTOR?

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WHEN the disturbing and painful symptoms of herpes zoster, or the stinging distress of neuritis brings the patient to you, quick relief is expected. Protamide helps solve this therapeutic problem by providing prompt and lasting relief in most cases. This has been established by published clinical studies, and on the valid test of patient-response to Protamide therapy in daily practice.

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In a recent study* of 104 patients, complete relief was obtained in 80.7% with Protamide. 49 were discharged as cured after 5 days of therapy with no subsequent relapse. (Without Protamide, the usual course of the type of neuritis in this series has been found to be three weeks to over two months.)

Dosage: one 1.3 cc. ampul intramuscularly, daily for five to ten days.

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A study* of fifty patients with Protamide therapy resulted in excellent or satisfactory response in 78%. (No patient who made a satisfactory recovery suffered from postherpetic neuralgia.) Thirty-one cases of herpes zoster were treated with Protamide in another study.* Good to excellent results were obtained in 28.

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ALLANTOMIDE VAGINAL CREAM WITH 9-AMINOACRIDINE

Encompasses A Wide Range Of Specific And Mixed Infections

Because it possesses both *bactericidal* and *fungicidal* action AVC is particularly valuable in the treatment of vaginitis due to mixed infections (including certain fungi, Gram-positive cocci, Gram-positive and Gram-negative bacilli, anaerobic organisms),¹ probably as a result of "... an apparent synergistic action existing between sulfonamides and 9-aminoacridine . . .".²

AVC is considered specific therapy against T.V.V., and is exceptionally effective in moniliasis.

AVC is non-staining, deodorizing, easy-to-use. Supplied in 4-oz. tubes, with or without plastic applicator.

1. Hensel, H.A.: Postgrad. Med., 8:293, 1950.
2. Spotts, S.D.: Am. J. Surg., 74:183, 1947.

FORMULA:

9-Aminoacridine hydrochloride	0.2%
Sulfanilamide	15.0%
Allantoin	2.0%
with lactose in a water-miscible base, buffered with lactic acid to pH 4.5	

Forensic Medicine

ARTHUR L. H. STREET, LL.B.

*Prepared especially for
Modern Medicine*

PROBLEMS: [1] Under a statute forbidding a medical practitioner to testify as to information gained in attending a patient professionally and necessary to enable him to prescribe for the patient, was the benefit of the statute waived by the widow of the patient authorizing the doctor to give a life insurance company's representative information concerning the insured patient's illness and cause of death? [2] Did the statute preclude the doctor from testifying, in a suit on the life insurance policy, to his having observed a growth on insured's face during social contacts with him, before any professional relationship existed between them?

COURT'S ANSWERS: [1] No. [2] No.

The U. S. Court of Appeals, Sixth Circuit, so decided in a case governed by Michigan statutes.

On the second question, the court said that the fact that the doctor may have utilized the information gained by social observation when he later made a professional diagnosis did not render the information privileged, because the Michigan statute limits the bar to information gained in a professional capacity as well as for diagnostic use (196 Fed. 2d 968).

PROBLEM: On recommendation of the family physician, a patient was taken to a hospital and a surgeon was engaged to set a broken hip, which he did by pinning. Later the patient sued the surgeon for chemical burns extending from the back to below the hips. Did this injury imply that defendant was negligent?

COURT'S ANSWER: No.

Because the hospital prepared the patient for the operation and furnished the chemicals which were applied by employees, the Ohio Court of Appeals, Hamilton County, said there was no basis for inferring that the burns were the fault of defendant. The evidence showed that he properly treated the burns when informed of them (103 N. E. 2d 13).

PROBLEM: In a Wisconsin lawsuit, question was raised as to the mental capacity of an 84-year-old man to deed property. A 65-year-old doctor, with forty years' experience in treating nervous and mental diseases, examined the man two and four years after the deed was executed. The doctor based an opinion of mental incapacity upon a diagnosis of cerebral arteriosclerosis and upon the usual course of progressive senility indicated by common experience and the second examination. Although he had examined more than 2,000 cases in courts, his qualification to render the opinion was challenged on the ground that his status as an expert was not established. Was he a trustworthy witness?

COURT'S ANSWER: Yes.

The Wisconsin Supreme Court rejected argument that the doctor's opinion was based upon conjecture

(Continued on page 45)



The Distracting Agony of Hemorrhoids

The torment of hemorrhoids disrupts normal mental processes. Reason, reflection, decision are difficult.

Physicians have for many years prescribed safe, sure Anusol Suppositories, which have given quick relief and peace of mind to thousands of men and women. For use with the Suppositories, we have now added Unguent made of the same ingredients.

The Anusol Suppository quickly forms a soothing, protective film over the irritated rectal mucosa, providing almost immediate relief. The new Unguent, externally applied to inflamed areas, gives prompt, cooling comfort.

Suppositories: boxes of 6, 12 or 24; Unguent in 1 ounce tube. Warner-Chilcott Laboratories, Division of Warner-Hudnut, Inc., New York 11, N. Y.

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SUPPOSITORIES [®] UNGUENT

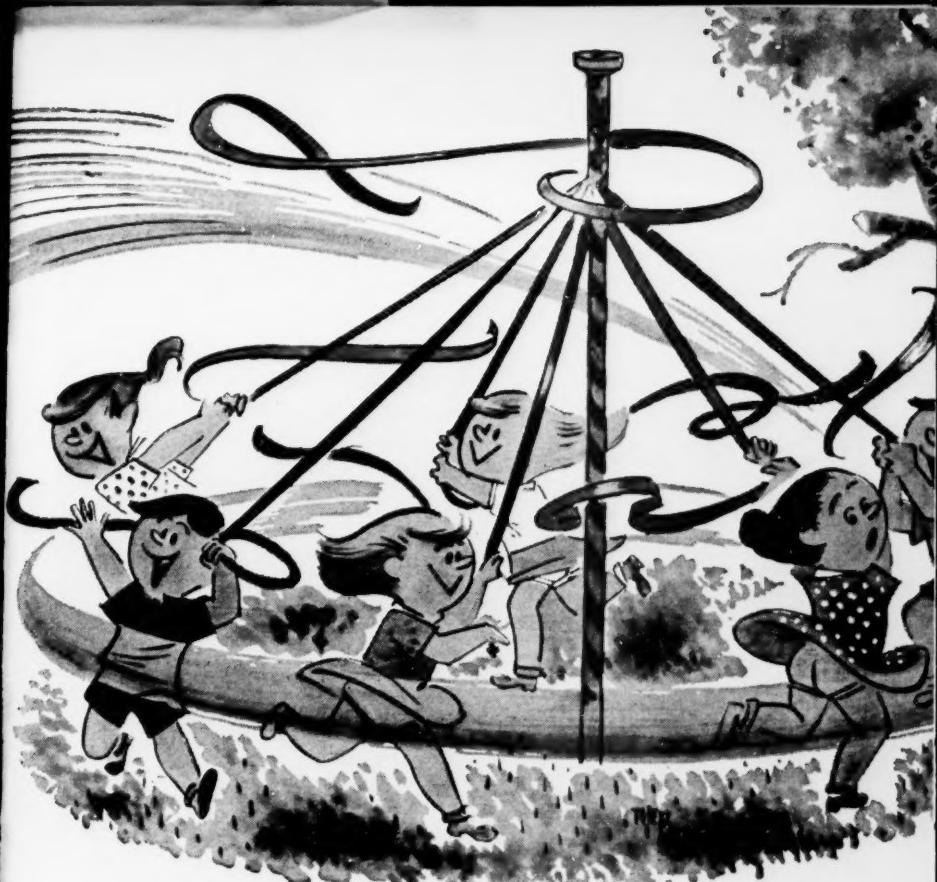
Prompt, Prolonged Relief Without Narcotics or Anesthetics



**He's
heard
the call
for**

IMPROVED FORMULA
Each 5-cc. teaspoonful
of VI-DAYLIN
contains:

Vitamin A..... 3000 U.S.P. units
Vitamin D..... 800 U.S.P. units
Thiamine Hydrochloride 1.5 mg.
Riboflavin 1.2 mg.
Ascorbic Acid 40 mg.
Vitamin B₁₂ Activity 3 mcg.
Nicotinamide 10 mg.



VI-DAYLIN®

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A lick of the spoon and a promise of more. That's all the "Call" he needs. And why not?

He already knows VI-DAYLIN's inviting aroma, its yellow-honey color and lip-smacking lemon-candy flavor. Vitamin-wise, you'll find a potent, carefully-balanced formula hidden beneath VI-DAYLIN's delicious taste. Each spoonful is a serving of *seven* important vitamins—including 3 mcg. of body-building B₁₂. And with synthetic vitamin A, there's not a trace of fish-oil.

VI-DAYLIN needs no pre-mixing, no refrigeration. Mother can pour it as is—mix it with milk, juices or cereal—and store it where she wishes. At all pharmacies in 90-cc., 8-fluidounce and 1-pint bottles. Won't you prescribe it **Abbott**

"Appestat Malfunction" is newest term for cause of Bulimia (Hyperorexia)



Development of atheromatous plaques is invariably accelerated in obese patients. These scarred aortas are from patients who succumbed (lower) at age 54, height 5'6", weight 210 lbs., and (upper) age 44, height 5' 5", weight 230 lbs.

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TABLETS

PHENYLPROPANOLAMINE HCl, THYROID AND VINBARBITAL



Since errors in excess of 25% will occur in estimating daily caloric expenditure if B.M.R. is not known, determination of a safe and effective reducing diet remains the physician's responsibility.



Exercise is of little help. To burn up a single pound of excess fat it would probably be necessary to walk at least from Philadelphia to Trenton²—and possibly all the way to New York.³

SHARP & DOHME, Philadelphia 1, Pa.

and ruled that because it was not impeached his opinion was entitled to consideration by the jury.

The court also rejected argument that "the testimony of experts is proverbially unreliable at best." The court said that an expert's testimony "sometimes appears to be unreliable or inconclusive," but that it had not previously heard a suggestion "that a court must or may arbitrarily reject the testimony of a medical expert upon the question of mental competency" (50 N.W. 2d 89).

PROBLEMS: A physician, in diagnosing a patient's condition, used observations made in social contacts that preceded professional relationship. [1] Did this disqualify the physician from testifying to those observations in a suit by a business beneficiary on a policy insuring the patient's life? [2] Did the Michigan statute, which renders doctor-patient communications confidential, prevent the doctor from giving expert testimony concerning skin diseases, pigmented moles, and melanoma generally, no reference to the patient's condition being made? [3] Could the doctor testify to the date upon which he attended the patient? [4] Under Michigan law, could the widow of the patient—not a beneficiary under the policy—waive the statutory bar against the doctor testifying to communications with the patient, to the prejudice of the beneficiary?

COURT'S ANSWERS: [1] No.
[2] No. [3] Yes. [4] No.

The U. S. Court of Appeals, Sixth Circuit, in upholding a decision of the U. S. District Court, Western District of Michigan, also declared that the fact that a death certificate made by the doctor was admitted in evidence did not permit the doctor to testify generally concerning the patient's condition (196 Fed. 2d 968).

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Doctor Draft Again Up for Revision and Extension

DURING May, the most important medical story in Washington was a well-rehearsed tussle over a familiar issue: How many doctors does the military really need, and what is the fairest way to call them?

The problem started seven years ago, at the end of World War II, when reserve medical officers went off duty faster than replacements could be signed up, even for the smaller Army, Navy, and Air

Force. The problem became critical after the start of the Korean war and resulted in the hurriedly written and enacted Doctor Draft Act. That law has been extended and patched up once and now is up for another repair job and extension.

All fall and winter military officials worked on the problem, frequently calling on the American Medical Association and the American Dental Association for advice.

When fairly close agreement was reached, Defense Department drew up a bill and made it public. Meanwhile, the new administration had taken over and wanted to have its own people check up on the new doctor draft plans.

The result was that National Selective Service, the Bureau of the Budget, the Office of Defense Mobilization, and several other government agencies gave the draft bill a thorough going over. As finally introduced, it was identified as the Defense Department's bill, but it wasn't the same one the



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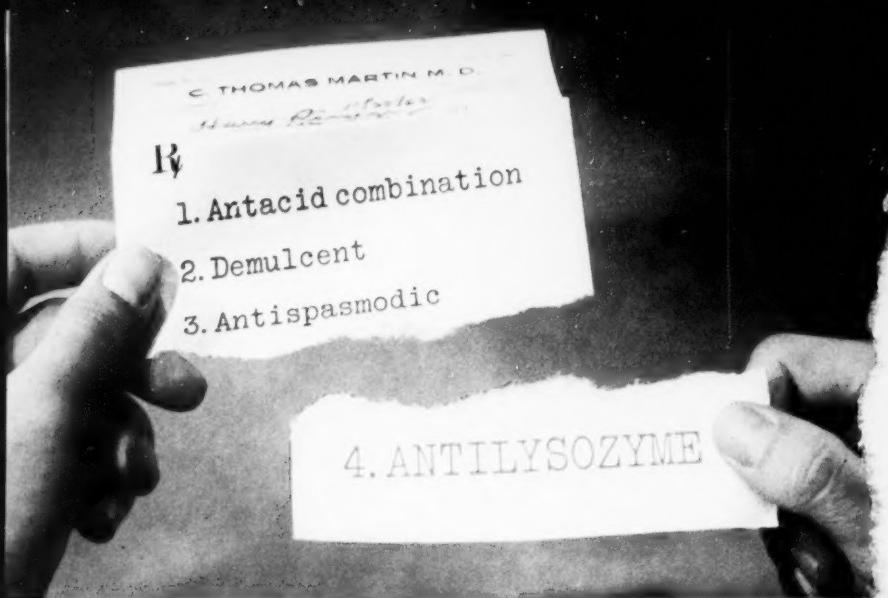
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department had proudly unveiled some months before.

The bill that Congress went to work on retains the same four priorities of physician registrants. This decision was made in view of practical considerations—so few Priority I and II men hadn't served or weren't serving that these groups no longer counted. That left two groups: Priority III, composed of men who have had no previous service, and Priority IV, those who have had service, but were not under special obligation, as were Priorities I and II, because of government-paid education or draft deferment as students.

Several points in the bill were designed to remove grounds for complaints from doctors that they were unable to [1] obtain commissions merited on the basis of education and experience, and [2] resign commissions on return to civilian life.

The bill states that any reserve medical officer now in service or subsequently called will be commissioned in a grade commensurate with his professional qualifications. Historically, the services' tables of organization and budgets have exerted a drag on the level of medical commissions, although each commission in theory is expected to be based on qualifications. This bill would remove both limitations and also specifically waive a law calling for approval of a board before a man who has not served before can be commissioned higher than major or lieutenant commander.

On the question of resigning reserve commissions after performing the required active duty, the bill is unequivocal. It states that the com-

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WASHINGTON LETTER

mission shall—not may—be terminated when the medical officer completes his active duty. Reentry into the reserves could be arranged upon application. But first the physician would be separated from his commission.

Although too late now to help them, this is interesting to a number of Naval medical officers who found resignation of commissions impossible at the end of World War II. This provision is made retroactive to September 1950, when the doctor draft law went into effect, but does not benefit men separated from service before that date.

Two limitations were placed on extent of duty, but one was certain

to come under criticism from World War II men with long years of service. The maximum duty period would be two years. However, if a man served twelve months after the start of the Korean war, he couldn't be recalled except in case of war or national emergency declared by Congress. But World War II veterans with twelve months' service after September 16, 1940, could be called back for seventeen months. The objective, of course, is to scoop up those men who have had only a few months of service, yet are in Priority IV. To do that, it was unavoidable that men with many years' service be reminded that they, too, may be called back.

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[†]Busic, S. N., and Friedman, L. L.: Antibiotics & Chemotherapy 3:299 (March) 1953.

WASHINGTON LETTER

Two other provisions of the bill would retain the maximum induction age at 51, rather than reduce the limit to 41 or 45 as first proposed by the military, and make qualified aliens eligible for commissions.

The bill had nothing at all to say about two of the points on which the American Medical Association and other professional groups had been pressing hard for months. No reference was made to a maximum ratio of physicians to troops. On this, however, the new administration is attempting to force action by applying its own pressure; military planners are expected to reduce the ratio from 3.7 per 1,000 to as close to 3 as possible without

seriously curtailing service to uniformed personnel.

Closely allied to this problem is the question of care of civilian dependents of uniformed personnel. There is no question that the military should provide such care when good civilian care is not available; there is a question of the equity or wisdom of drafting physicians to care for servicemen's wives and children in such cities as Washington, D. C., Chicago, Los Angeles, and San Francisco, where the supply of civilian doctors or hospitals is ample; again the bill is silent.

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WASHINGTON LETTER

port issued at about the same time does not. It is the report of a commission named by Defense Department to study special and incentive pay problems, and headed by Lewis L. Strauss.

The report recommends flatly that the special \$100 a month pay given to physicians, dentists, and veterinarians be withheld from men serving only the required time under the doctor draft law. The reasoning is that men who serve as doctors only the time that non-physicians have to serve under the regular draft are entitled to no special financial consideration. However, extra pay for members of the regular corps and for reserves going on active duty for

longer than the required two years would still be allowed.

The bill made no mention of special pay, but subsequently the Defense Department introduced separate legislation covering the subject.

The Strauss report also did no fence-straddling on the question of caring for civilian dependents. It proposed continuance of medical care "wherever possible," which is exactly the current policy of the military services.

Washington Notes

¶ Despite the long-range study of federal-state relations, which was supposed to result in a freeze on all medical and welfare legislation this

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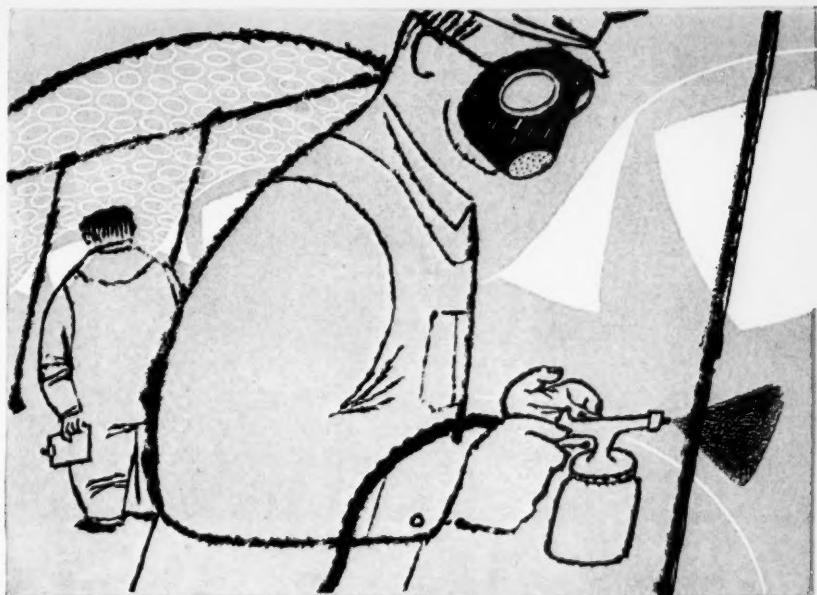
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session, there is a strong possibility that Old Age and Survivors Insurance will be extended to practically everyone past 65 years of age, whether or not they have paid a penny in OASI payroll taxes. This idea, pushed vigorously by the U. S. Chamber of Commerce, has won a great deal of support from the President's closest advisers, if not on Capitol Hill.

¶ When the Senate Finance Committee went through the formality of holding a public hearing on the confirmation of Mrs. Hobby as secretary of the new Department of Health, Education and Welfare, only one die-hard critic appeared to argue against her. The critic was Marjorie Shearon, a writer and long-time opponent of the Social Security system. Unimpressed, the committee unanimously endorsed Mrs. Hobby just as soon as Mrs. Shearon had finished giving her testimony.

¶ The first appointment in the new department was that of Park M. Banta, a Missouri attorney, as general counsel. Mr. Banta is a middle-roader, who became an expert on Social Security while heading Missouri's Social Security administration.

¶ Delay of many local medical advisory committees in processing Priority III men has built up an awkward situation. While enough younger men are in the group to take care of military demands for many months, only a few have been processed for commissioning. As a result, large numbers of older men in the same group, who just happen to be ready for commissioning, are being taken in to fill quotas. Understandably, they don't like it.



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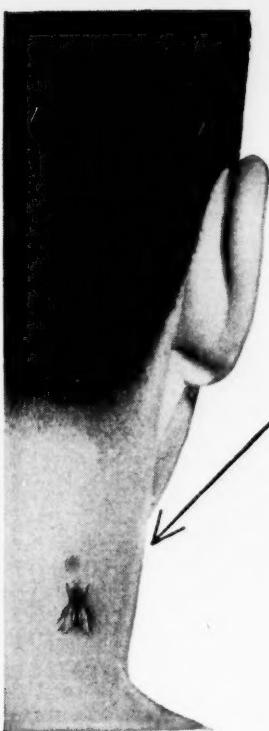
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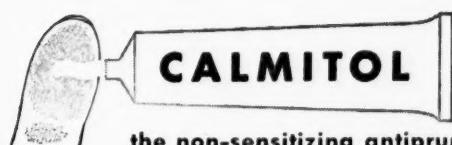
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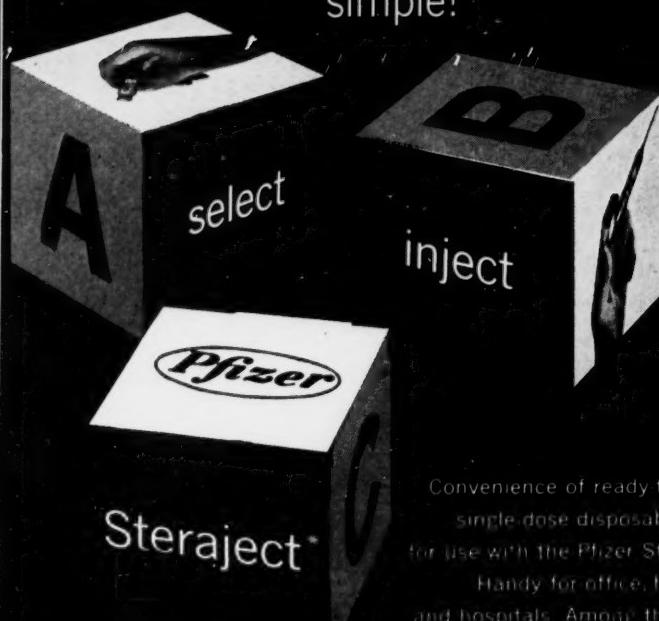
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1. Zimmerman, A. B., and others: A Comparative Study of Sodium-free Salt Substitutes. Am. Pract. & Digest. Treat. 2:168, 1951.

2. Fremont, R. E., and others: Postgrad. Med. 10:216, 1951.

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DESCRIPTION: Each fluid ounce contains:

Iron and Ammonium Citrate	18 grs.
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DOSAGE: As a hematinic and nutrient tonic 1 to 3 teaspoonfuls daily. For maintenance in pernicious anemia 2 tablespoonfuls daily.

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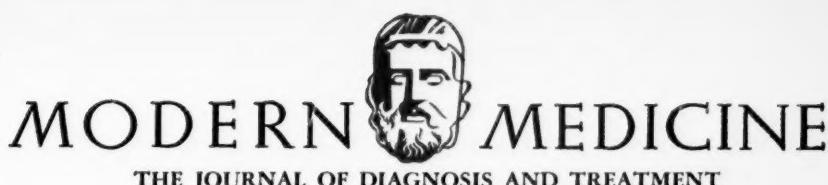
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Laboratory Reports *not always infallible*

A Modern Medicine Editorial

Some years ago a research worker in a great medical institution wrote a paper in which he drew definite conclusions on the basis of small differences in a series of averaged red cell counts. Because the editor doubted the validity of the conclusions, he asked the writer to consult a statistician.

The statistician said that he could easily estimate the "probable error" of the "means" or averages and that then he could say what the probability was that the differences between the several means were significant. However, he would first have to know the error of the counts. The pathologist who had written the paper said that with counts made as his were, by well-trained girls who did such work all day, he doubted if the error would be over 50,000 or at most 100,000, but he hadn't tested to see.

The statistician said that the paper wasn't worth anything until they knew what the error of the method was. Accordingly, they had a dozen girls take blood from the finger of one man and count the red cells. The error in the counts turned in ranged all over 1,000,000 cells!

I have heard Dr. Wintrobe say that the red cell count is so inaccurate that he much prefers the hematocrit reading with packed red cells. The making of such a measurement takes little skill and little time. All of which should remind us never to worship laboratory reports, as many of us now do.

Perhaps even more inaccurate than the average red cell

EDITORIALS

count is the average hemoglobin reading made with one of the cheap instruments. Several such readings made for one person and perhaps with different instruments will vary by 20%. As a result, every year a consultant sees 100 or more persons being treated for anemia who, according to the electric hemoglobinometer, are perfectly normal.

WALTER C. ALVAREZ

Severe Distress after Taking an Antibiotic

All doctors should be watching constantly for the severe reactions to antibiotics that are now so common and often so distressing and disabling. Unfortunately, although everyone does know about these reactions, until recently almost no one has written about them. A splendid review of the subject by Maxwell Finland and Louis Weinstein is to be found in the *New England Journal of Medicine*, Feb. 5, 1953. All should read it.

The worst feature of the situation is that not infrequently a patient who has reacted violently and perhaps allergically to a big dose of one antibiotic, instead of not being given any antibiotic, is promptly treated with another and becomes worse.

If it were kept in mind how common these reactions to antibiotics are they would be recognized more readily and the patient saved much distress.—W.C.A.

Atabrine and Rheumatoid Arthritis

Over a year ago, in the London *Lancet*, Dr. F. Page reported beneficial effects from giving atabrine to a couple of patients with lupus erythematosus. Later, Dr. Arnfinn Engeset of Stavanger, Norway, reported that the drug greatly helped a number of patients with rheumatoid arthritis and asthma. Recently, in this country, some encouraging results have likewise been noted.—W.C.A.



SPECIAL EXHIBIT



ETIOLOGY

Vibration Approximation Tension

PATHOLOGY

Laryngeal disease
Chest, mediastinal, or neck disorders
Central nervous system disorders

A MODERN MEDICINE Special Exhibit adapted from the presentation made by James J. O'Neil, M.D., of Creighton University, Omaha, at the Chicago convention of the American Medical Association, including 16 illustrative cases.

CLASSIFICATION

Acute Chronic

SYMPTOMS Acute

Hoarseness—aphonia
Paroxysmal cough
Pain in larynx
Fever and chills

SYMPTOMS Chronic

Hoarseness—intermittent
Local discomfort
Tickling sensation—cough
Clear throat before speaking

DIAGNOSIS

History, present, family, past
Laryngeal examination
Indirect—mirror
Direct—laryngoscope
Palpation
X-ray
General medical examination
Serologic and bacteriologic tests

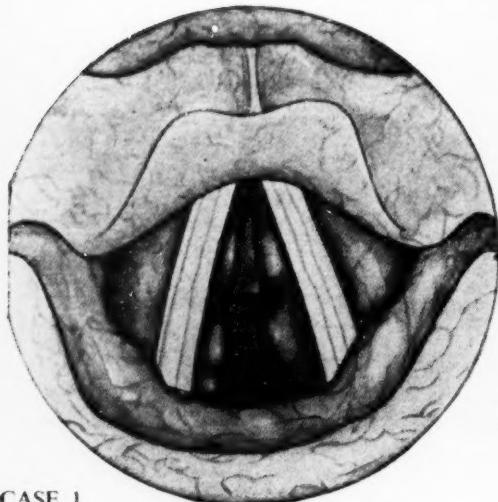
TREATMENT

Endo- or extralaryngeal surgery
Chest or neck surgery
Medical, neurologic, or psychiatric management

SPECIAL EXHIBIT

ACUTE LARYNGITIS

A. K., white female, age 39 years



CASE 1

HISTORY:

Hoarseness—two weeks. Onset after acute upper respiratory infection with bilateral maxillary sinusitis. Indirect laryngeal examination revealed acute laryngitis secondary to acute upper respiratory infection and sinusitis.

TREATMENT:

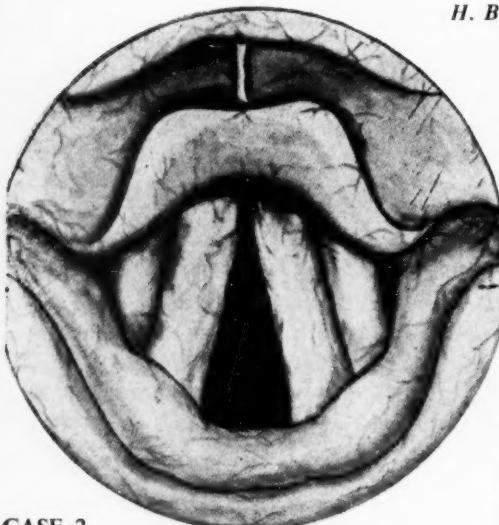
Medical regime, antral irrigations, voice rest

RESULT:

Uneventful recovery with return of normal voice

CHRONIC LARYNGITIS

H. B., white female, age 45 years



CASE 2

HISTORY:

Hoarseness—eight months, worse in last two. Chronic smoker and chronic dry cough. Indirect laryngeal examination revealed moderate thickening with marked congestion of both vocal cords without sign of neoplasm. Results of chest roentgenograms were negative.

TREATMENT:

Medical management, no smoking, strict voice rest

RESULT:

Marked improvement in ten days; complete return of normal voice and cessation of cough in three weeks

SPECIAL EXHIBIT

KERATOSIS OF LARYNX

F. Mc., white male, age 52 years

HISTORY:

Hoarseness—six months, progressively worse. Indirect laryngeal examination revealed whitish elevated thickened area involving middle third of left vocal cord. Direct laryngoscopic examination confirmed these finds. Biopsy report was keratosis of left vocal cord.

TREATMENT:

Endolaryngeal removal of keratotic area with straightening of phonating edge of vocal cord

RESULT:

Symptom free; no recurrence of keratotic area



CASE 3

NONSPECIFIC GRANULOMA OF LEFT VOCAL CORD

A. F., white male, age 49 years

HISTORY:

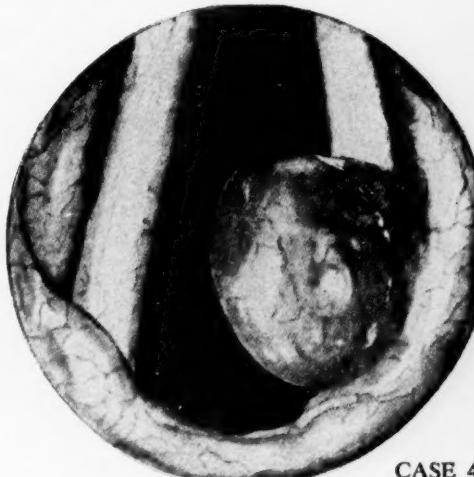
Hoarseness—two months, gradually worse. Indirect and direct laryngeal examination revealed large benign tumor mass arising from posterior third of right vocal cord.

TREATMENT:

Endolaryngeal removal, tissue reported as nonspecific granuloma

RESULT:

Normal voice in twenty-four hours

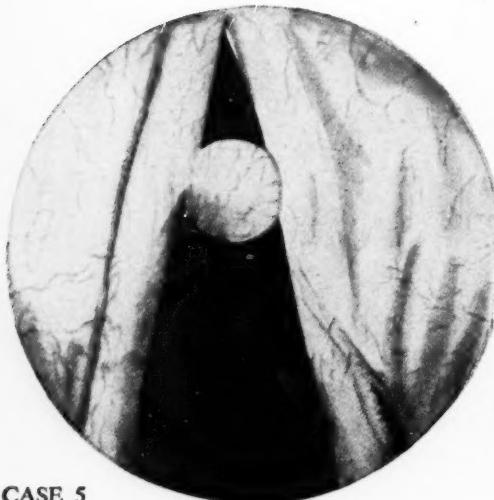


CASE 4

SPECIAL EXHIBIT

POLYP OF LARYNX

N. G., white male, age 55 years



CASE 5

HISTORY:

Hoarseness with aphonia—three months. Indirect laryngeal examination revealed tumor mass involving anterior third of left vocal cord. Direct laryngoscopy and biopsy done. Tissue reported as benign polyp of left vocal cord.

TREATMENT:

Endolaryngeal removal

RESULT:

Normal voice in ten days,
symptom free to date

VASCULAR POLYP OF LEFT VOCAL CORD

G. D., white male, age 38 years



CASE 6

HISTORY:

Hoarseness—six weeks. Indirect and direct laryngeal examination revealed hemorrhagic polypoid tumor on anterior third of left vocal cord, resembling a hemangioma.

TREATMENT:

Endolaryngeal removal of tumor which histologically was reported as a vascular polyp

RESULT:

Normal voice in ten days,
symptom free

SPECIAL EXHIBIT

CONTACT ULCER AND GRANULOMA OF LARYNX

E. J., white male, age 47 years

HISTORY:

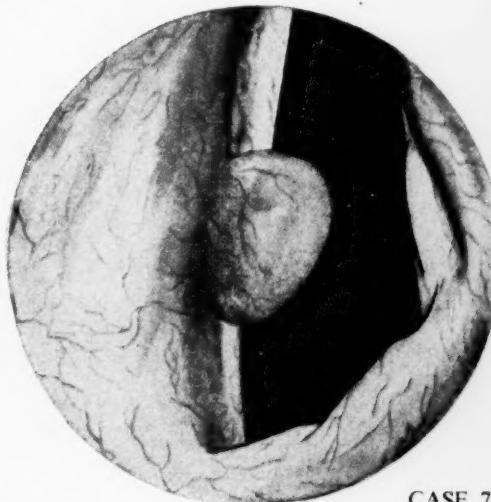
Hoarseness—nine months. Sudden onset, persistent despite several endolaryngeal removals of tissue, which recurred. Indirect laryngeal examination revealed mass of granulation-like tissue on posterior third of left arytenoid.

TREATMENT:

Endolaryngeal removal of granulation tissue which was histologically a nonspecific granuloma with a contact ulcer. Phonating edge of vocal cord was aligned. Patient was sent to speech correctionist

RESULT:

Marked improvement in voice which is gradually returning to normal with correction of faulty speech mechanism



CASE 7

POLYP AND MUCOID METAPLASIA OF LARYNX

M. W., white female, age 30 years

HISTORY:

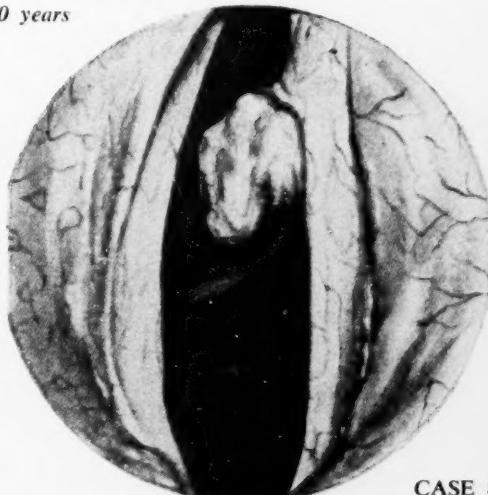
Intermittent hoarseness with aphonia—six months. Laryngeal examination revealed polypoid-like mass on middle third of right vocal cord.

TREATMENT:

Endolaryngeal removal of tissue which was histologically reported as a benign polyp with mucoid metaplasia

RESULT:

Normal voice, symptom free

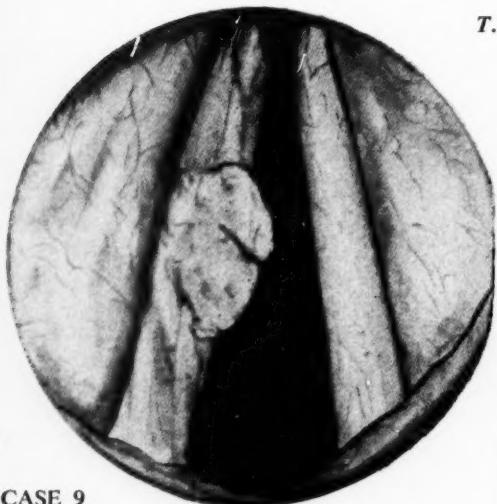


CASE 8

SPECIAL EXHIBIT

EARLY LARYNGEAL CARCINOMA WITH UNILATERAL CORD INVOLVEMENT

T. P., white male, age 57 years



CASE 9

HISTORY:

Hoarseness—two months, following a sore throat. Indirect laryngeal examination revealed a large bulky neoplastic lesion on middle third of left vocal cord. Biopsy was reported as squamous-cell carcinoma.

TREATMENT:

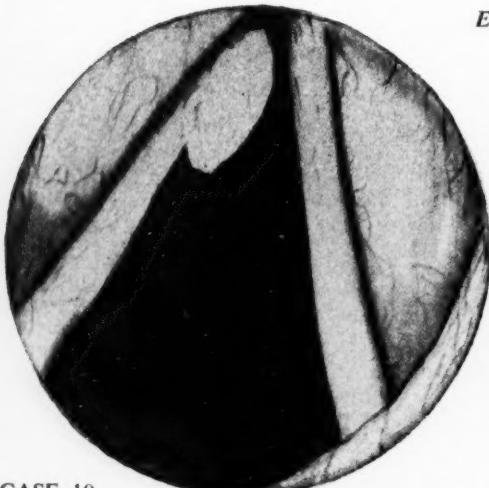
Extralaryngeal approach with resection of involved cord

RESULT:

No recurrence, serviceable voice

EARLY BENIGN-APPEARING CANCER: UNILATERAL CORD INVOLVEMENT

E. L., white male, age 67 years



CASE 10

HISTORY:

Hoarseness—two months. Indirect laryngeal examination revealed a grayish-appearing elevated nodule on anterior third of left vocal cord, which appeared to be a benign vocal nodule. Direct laryngoscopy and biopsy revealed a squamous-cell carcinoma of the larynx.

TREATMENT:

Extralaryngeal approach with resection of involved cord

RESULT:

No recurrence after two years, serviceable voice

SPECIAL EXHIBIT

LARYNGEAL CANCER INVOLVING BOTH CORDS AND ANTERIOR COMMISSURE

J. B., white female, age 24 years

HISTORY:

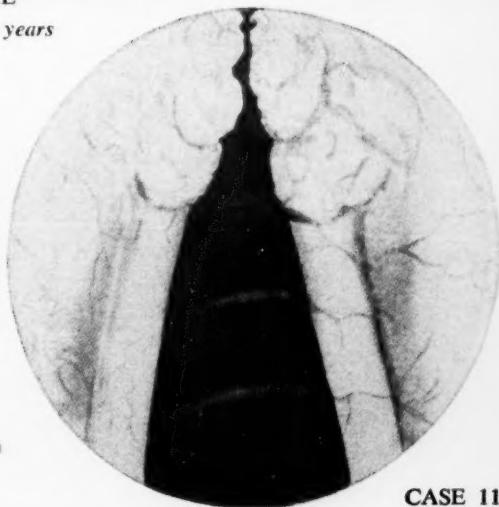
Hoarseness—all of patient's life. Repeated direct laryngoscopies with biopsies showed multiple papillomas of both vocal cords and anterior commissure until biopsy (2-28-50) showed carcinomatous degeneration of papillomas involving both vocal cords and anterior commissure.

TREATMENT:

Total laryngectomy

RESULT:

Three-year cure with no recurrence. Pharyngeal speech has rehabilitated patient to position of office employee



CASE 11

TUBERCULOUS LARYNGITIS SECONDARY TO PULMONARY TUBERCULOSIS

W. H., white male, age 53 years

HISTORY:

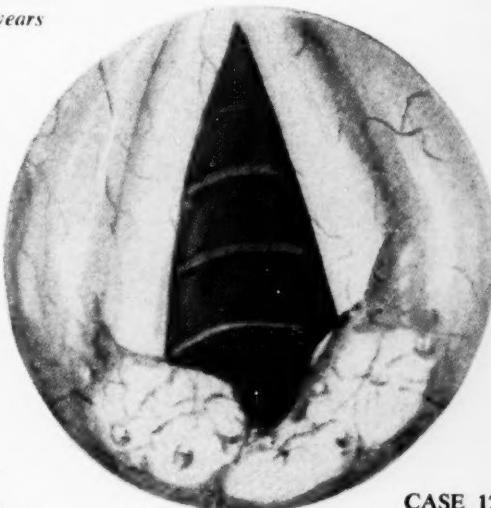
Hoarseness—three weeks. Indirect and direct laryngoscopic examination revealed marked inflammatory reaction with ulceration of posterior third of both vocal cords and interarytenoid area. Tissue from posterior commissure histologically reported as tuberculous laryngitis. Chest roentgenograms revealed active pulmonary tuberculosis.

TREATMENT:

Medical regime, strict voice rest, streptomycin

RESULT:

Considerably improved voice. Pulmonary tuberculosis is responding to sanatorium care

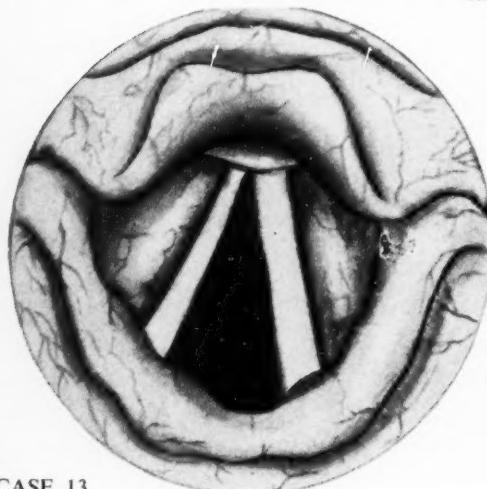


CASE 12

SPECIAL EXHIBIT

AORTIC ANEURYSM CAUSING LARYNGEAL PARALYSIS

A. S., white male, age 51 years



CASE 13

HISTORY:

Hoarseness—four weeks. Indirect and direct laryngoscopic examination revealed complete paralysis of left vocal cord. Chest roentgenograms revealed aortic aneurysm.

TREATMENT:

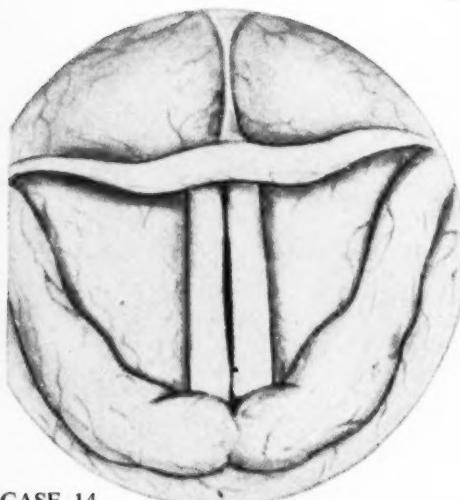
Medical regime

RESULT:

No change in voice quality

POSTTHYROIDECTOMY BILATERAL CORD PARALYSIS

A. G., white female, age 62 years



CASE 14

HISTORY:

Hoarseness and dyspnea after thyroidectomy. Indirect and direct laryngoscopic examinations revealed bilateral abductor paralysis.

TREATMENT:

Extralaryngeal approach with fixation of right arytenoid and cord laterally

RESULT:

Serviceable voice, dyspnea free

SPECIAL EXHIBIT

HYSTERIA CAUSING HOARSENESS

H. G., white female, age 40 years

HISTORY:

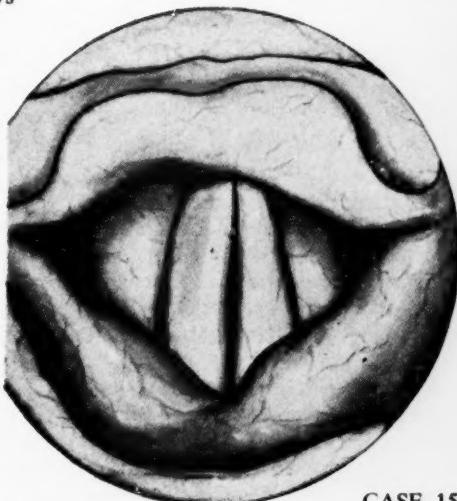
Hoarseness with aphonia—thirty years, after blow to neck by baseball. Laryngeal examination revealed a normal larynx.

TREATMENT:

Psychiatric

RESULT:

Favorable response with improvement in voice to date



CASE 15

FOREIGN BODY

D. C. B., white male, age 23 years

HISTORY:

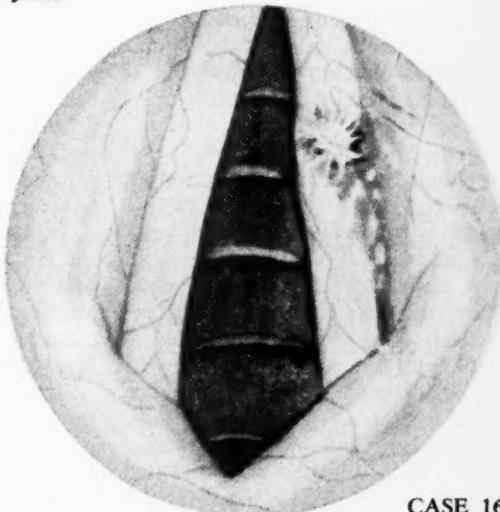
Pain and hoarseness—two days. On a hunting trip patient tried to dislodge a sandbur from his glove with his mouth. The bur was suddenly aspirated and the patient developed immediate pain, cough, and hoarseness. Indirect laryngeal examination revealed a bur embedded in the midportion of the right vocal cord.

TREATMENT:

Direct laryngoscopy and removal

RESULT:

Normal voice in ten days



CASE 16

The factor or factors causing chronic diarrhea must be identified if treatment is to be successful.

Diagnostic Studies in Chronic Diarrhea

FREDERICK STEIGMANN, M.D.
University of Illinois, Chicago

THE many possible causes and the confusing secondary effects on other organs often make chronic diarrhea a baffling problem. Extensive diagnostic procedures may be necessary before effective treatment can be found.

Frederick Steigmann, M.D., lists 10 major factors or types of involvement (see table).

Among clues sought in the record are any change in dietary habit, work with noxious materials, travel to endemic areas, nature of bowel movements, and symptoms such as nausea, flatulence, or tenesmus.

Physical, rectal, and proctoscopic examinations must be thorough. Stools should be inspected by a parasitologist and cultured for various pathogens.

Röntgen films include the esophagus, stomach, duodenum, small bowel, and biliary tract. The colon is viewed with barium and air techniques.

A number of laboratory procedures may be important. Gastric analysis is generally done with a histamine test meal, 0.1 mg. per 10 kg. of body weight, to exclude achlorhydria.

Urinalysis will show glycosuria, albuminuria, bilirubinuria, and the

Chronic diarrhea—diagnosis and management.

presence or absence of urobilinogen.

Blood counts indicate anemia, leukocytosis or leukopenia, and other abnormalities. Blood agglutination tests may reveal *Salmonella* or *Shigella* infection. Useful blood chemistry procedures determine glucose, urea, cholesterol, albumin, globulin, calcium, phosphorus, and alkaline phosphatase levels.

Blood serum should be investigated. Basal metabolic rates may disclose hyperthyroidism.

The most common causes of chronic diarrhea, in order of frequency, are emotional or nervous factors, chronic ulcerative colitis, cancer of the colon, gastric disease, amebic colitis, constitutional disorders, disorders of gallbladder and pancreas, nutritional deficiency, and tuberculous and nonspecific enteritis.

Secondary effects in other organs are fistula, nutritional disease, hepatic involvement, which may be amebic, toxic, or metastatic, and disturbances of the bladder, ureters, or kidneys.

Treatment obviously depends on the cause and may consist merely of replacing acid or pancreatin. In most cases the diet should be high

J. Indiana State M. A. 46:207-212, 1953.

MAJOR FACTORS OR TYPES OF INVOLVEMENT

1] GASTROGENOUS TYPE, caused by primary achlorhydria or a gastric operation such as gastroenterostomy or gastric resection

2] PANCREATIC TYPE, resulting from enzymatic deficiency

3] CHRONIC GALLBLADDER DISEASE, caused by associated gastric and pancreatic conditions. Rarely, the condition may be the result of a fistula between biliary and alimentary tracts.

4] CONSTITUTIONAL DISORDERS, such as allergy, diabetes, or hyperthyroidism, involving achlorhydria or hypermotility, or chronic nephritis

5] FUNCTIONAL DISORDERS, including constipation, fecal impaction, mucous colic, or emotional upset

6] NEUROGENIC DISTURBANCES, reflex disorders from intraabdominal abscess, renal or biliary colic, or central nervous disease

7] GYNECOLOGIC DISEASE, including endometriosis or post-irradiation enteritis or colitis

8] IATROGENIC FACTORS, especially treatment with antibiotics

9] DEFECTIVE ABSORPTION because of idiopathic steatorrhea, tuberculous mesenteric glands, deficiency states like sprue or pellagra, or intestinal carbohydrate dyspepsia

10] INTESTINAL DISEASES

Infections—bacillary dysentery, typhoid fever, mycosis, lymphopathia venereum

Parasites

a] Protozoa: *Amoeba histolytica*, *Trichomonas hominis*, *Giardia lamblia*, *Balantidium coli*, *Leishmania*

b] Helminths

Toxic drugs—arsenic, mercury, alcohol

Neoplasm—polyposis, cancer
Anomalous states—megacolon, diverticulosis

Inflammations—diverticulitis, factitious proctosigmoiditis

Ulcerative disease—tuberculosis, chronic nonspecific enteritis, enterocolitis, ulcerative colitis.

in calories, protein, and vitamins, with moderate amounts of carbohydrate and fat, and several small meals per day.

Blood transfusion, intravenous solutions, iron, antibiotics, parenteral liver, a vermicide, or other measures may be indicated.

Surgery is done for cancer and for ulcerative colitis in cases with massive hemorrhage, impending or

actual perforation, stricture, perineal fistula, and perhaps with polypoid changes or severe arthritis. Polyps within reach of the sigmoidoscope are removed.

Permanent ileostomy now permits a fairly normal life for patients with a little adaptability and will power. Postoperatively, some women even marry and have children.

Relief from fainting episodes caused by carotid sinus reflex may be achieved from x-ray therapy.



Carotid Sinus Syndrome

HUGH P. GREELEY, M.D.
Lahey Clinic, Boston

ROENTGEN radiation not only gives prompt relief in cases of carotid sinus syndrome but administration is harmless, inexpensive, and not prolonged.

The response is good whether the type of syncope is vagal, depressor, cerebral, or mixed. All but 1 of 13 roentgen-treated patients have been free from syncope for six months to six years, reports Hugh P. Greeley, M.D.

TREATMENT

Using the technic of Stevenson, 3 roentgen exposures are given in one week, using 200 to 220 kv. with 2 mm. of copper and 1 mm. of aluminum filters, 50 cm. T.S.D., 200 r with a 10-cm. round portal. Occasionally, 1 or 2 similar exposures are added to this therapy.

The principal drug used for medical therapy is atropine or some form of belladonna, given over a considerable period of time, combined with 1/4 gr. of phenobarbital if the patient is apprehensive. Epinephrine in emergencies and ephedrine are used to reduce the risk of asystole by rendering the cardiac muscles more irritable and less liable to vagal stimulation.

Treatment by surgical denervation has been successful in a few Notes on carotid sinus syndrome. Lahey Clin.

instances. However, the technic is dangerous except in skilled hands and is no longer a recommended procedure.

DIAGNOSIS

Typical aura of carotid sinus syndrome are tinnitus, blurring of vision or visual hallucinations, light-headedness or sensation of fullness in the head, and numbness and tingling in the hands and feet. At other times episodes are ushered in with a shrill cry, apnea or hyperpnea, weakness, faintness, dizziness, a bloating sensation, nausea, vomiting, and, rarely, anginal pain.

Syncope follows rapidly, with or without convulsions and loss of sphincter control, depending on the duration of the attack, which is rarely more than a few seconds. Complete recovery is often accompanied by a startled look on the patient's face, who is unaware of what has happened.

Lassitude and severe anxiety may delay recovery for hours or days. Occasionally, if the period of syncope is prolonged a few seconds, the attack may be followed by monoplegia, hemiplegia, or even death.

The condition must be differentiated from cerebrovascular disease Bull. 8:90-94, 1953.

and possible minor cerebrovascular accidents.

Carotid pressure is not attempted for diagnosis if the patient has heart disease and should not be done if the patient is elderly unless clearly necessary, as when incapacitating episodes are not controlled by usual methods. When the test is performed on an elderly person,

the patient ought to be lying down.

Trigger mechanisms are frequently not recognizable. Attacks often follow a quick motion of the neck, pressure on the neck, straining, bending, or lifting. Pre-operatively some drugs should be avoided, especially morphine, digitalis, nitrites, desiccated thyroid, and Mecholyl.

Oral Procaine for Alimentary Disorders

DONALD C. BALFOUR, JR., M.D., GEORGE K. WHARTON, M.D.,
AND HOWARD SKY-PECK

RELAXATION of spasm, relief of pain, or control of bleeding by procaine is helpful in various gastrointestinal diseases.

For cardiospasm, esophagitis, or hiatal hernia, Donald C. Balfour, Jr., M.D., George K. Wharton, M.D., and Howard Sky-Peck of the University of Southern California and the Good Hope Clinic, Los Angeles, use a concentrated solution of procaine hydrochloride mixed with methylcellulose solution to a concentration of 300 mg. per dram. Preceding meals or when distress is felt, 1 or 2 tsp. may be taken at least five minutes before any food, liquid, or alkali is swallowed.

Patients with large saccular dilatation of the esophagus or elderly individuals with pronounced neuromuscular dysfunction of the esophagus may not be helped. The drug must contact mucosa for effect.

Gastritis may be relieved by 2 oz. of a 2% solution given three to six times daily. The patient may dissolve 20 gm. of procaine hydrochloride powder in 1 qt. of water.

Painful peptic ulcer is quieted within three or four minutes for an hour or two. However, since alkalies nullify effects, antacids should be delayed for fifteen to thirty minutes after procaine therapy. Anesthetic injected through a gastric tube relaxes the pylorus before intubation of the duodenum.

Vomiting caused by pregnancy, irradiation, or uremia may be stopped by a 2-oz. dose of 2% procaine given every two hours. In some cases of spastic bowel, ulcerative colitis, and postoperative jejunitis, procaine is also effective.

Use of procaine hydrochloride by mouth for gastrointestinal disorders. *Gastroenterology* 22:257-262, 1952.

*In some infections, a combination
of antibiotics works more effectively than
a single agent alone.*

Use of Antibiotic Combinations

HARRY F. DOWLING, M.D., MARK H. LEPPER, M.D.,
AND GEORGE G. JACKSON, M.D.
University of Illinois, Chicago

IN treatment of some infections, combinations of antibiotics have proved of value, though one antibiotic can be used with good results in most infections caused by a single organism.

The broad-spectrum antibiotics, aureomycin, terramycin, and chloramphenicol, may be employed against mixed peritoneal infections caused by a ruptured viscus. Single antibiotics are recommended by Harry F. Dowling, M.D., Mark H. Lepper, M.D., and George G. Jackson, M.D., for mixed infections when effectiveness is proved, such as penicillin for lung abscess.

Effective antibiotic combinations are streptomycin with aureomycin, chloramphenicol, or terramycin for brucellosis, and penicillin with streptomycin for enterococcal endocarditis. Staphylococcal infections that are resistant to one antibiotic often respond to penicillin and aureomycin, chloramphenicol, or terramycin.

Another indication for simultaneous use of several antibiotics is the appearance of resistance. Streptomycin is apparently the only important antibiotic requiring combination with other agents to diminish the development of resistant

When should antibiotics be used in combination? J.A.M.A. 151:813-815, 1953.

strains. If para-aminosalicylic acid is used with streptomycin in tuberculosis, the number of resistant forms is reduced. Sulfonamides may accomplish the same purpose when added to streptomycin in treating some gram-negative bacterial infections.

Penicillin and streptomycin act synergistically against enterococci. Streptomycin and aureomycin, terramycin, or chloramphenicol produce synergism against brucellosis. The same action will occur with combinations of penicillin and streptomycin, aureomycin, or terramycin against staphylococci resistant to penicillin. Synergism occurs between penicillin and bacitracin when used for *Treponema pallidum* and alpha or gamma streptococci.

Improperly combined antibiotics may produce antagonism. The effectiveness of penicillin is decreased, for instance, when broad-spectrum antibiotics such as aureomycin, chloramphenicol, or terramycin are combined with penicillin against infections caused by *Klebsiella*, hemolytic streptococci, or pneumococci. Similarly, antagonism occurs if streptomycin is used with one of the broad-spectrum antibiotics in

treating *Klebsiella* infections. Interference seems to be most pronounced when only small amounts of the broad-spectrum drugs are added to effective concentrations of penicillin.

Some infections will require *in vitro* studies of various combinations to determine greater synergism, providing the patient is not too ill to tolerate the delay. If delay is impractical, however, grouping the antibiotics according to bactericidal and bacteriostatic properties

assists rapid selection of effective combinations. Penicillin, streptomycin, bacitracin, and neomycin are primarily bactericidal and any 2 may be used together if each alone is partially effective. If only one bactericidal agent fits such criteria, combination with a bacteriostatic drug—aureomycin, chloramphenicol, or terramycin—of known effectiveness is used. Each ought to be given in full therapeutic doses to avoid possible antagonism.

Drugs for Suppression of Appetite

S. C. FREED, M.D.

MOST patients trying to reduce weight keep to a low-calorie diet far better with the help of drugs that curb appetite.

Salts of amphetamine have the most desirable properties, and a 1:3 levo-dextro ratio is satisfactory. S. C. Freed, M.D., of San Francisco recently obtained good to excellent results in 192 of 236 cases, with side reactions of nervousness, nausea, or headache in only about 6%.

Doses taken one-half to one hour before eating lessen the psychic urge to overindulge and will produce a sense of fullness after a moderate meal. Fatigue, irritability, and depression, frequent during restriction, are much relieved.

Vagotonic individuals, characterized by hypotension, a slow pulse, and low body temperature, are rather insensitive to appetite-suppressing power of dextroamphetamine alone. Racemic amphetamine, an equal mixture of levo and dextro forms, is potent and tolerated well.

Levoamphetamine, though inactive, reinforces the action of the dextro type but is chiefly responsible for untoward effects. Large doses may upset high-strung sympathotonic persons.

Biphetacel contains amphetamine phosphate in the effective levo-dextro proportion of 1 to 3 and also ingredients that prevent constipation. Sympathotonic patients should take 5 mg. and the vagotonic group 10 mg. three times a day.

Newer concepts in treating obesity. GP 7:63-68, 1953.

*A disease until now unfamiliar
to Western civilization has been encountered by
troops in Korea.*

Epidemic Hemorrhagic Fever

CHARLES L. LEEDHAM, M.D.
Far East Command

AN acute, fulminating, often fatal but otherwise self-limited disease, epidemic hemorrhagic fever is characterized by severe toxemia, widespread capillary damage, and hemorrhage.

Although the cause, vector, and conditions necessary for transmission are still unknown, the illness does not appear to be contagious.

PATHOLOGY

The outstanding pathological changes described by Col. Charles L. Leedham, M.C., A.U.S., result from hemorrhage. The most constant and prominent lesions occur in the kidney, heart, gastrointestinal tract, and lungs.

The kidney hemorrhage is severe and confined almost entirely to the medullary pyramids. In the pelvis, submucosal hemorrhages demarcated sharply at the ureteropelvic junction are found.

The heart reveals petechial involvement throughout but no valvular or coronary damage. Intense subendothelial hemorrhage is limited to the right auricle. Diffuse hemorrhage and interstitial edema occur in the myocardium of the right and left auricles and to a lesser extent in the ventricles.

Petechial and gross hemorrhages

Epidemic hemorrhagic fever: a summarization.

as well as congestion appear throughout the length of the gastrointestinal tract, but the liver, spleen, and pancreas are affected only slightly. Interstitial fluid and intraalveolar blood accumulate in the lungs. Hemorrhages in other parts of the body are found less often, but any organ or tissue may be involved to almost any degree.

The clinical course of the disease may be divided into invasive, toxic, and convalescent phases. The incubation period seems to be about twelve days with a range of seven to thirty days.

INVASIVE PHASE

The symptoms of the invasive phase are chiefly those of a systemic reaction. The onset, often initiated by a chill, is abrupt and accompanied by severe frontal or supraorbital headache, backache, and generalized muscular pains. Abdominal discomfort becomes increasingly severe and is accompanied by vomiting.

Photophobia, blurring of vision, retrobulbar ache, and pain with eye movement are characteristic. Sclerae are injected and infraorbital edema may occur.

The patient is acutely ill and restless. The face, neck, and upper

Ann. Int. Med. 38:106-112, 1953.

chest are flushed. The moderately enlarged cervical, axillary, and inguinal nodes are not tender. A temperature of 100 to 106° F. reaches a peak on the third or fourth day after onset and thereafter falls by lysis. The pulse is disproportionately slow and the blood pressure may drop to shock levels.

TOXIC PHASE

After the third or fourth day the white cell count suddenly rises, the sedimentation rate becomes elevated, the platelet count drops, and the bleeding time is prolonged. The appearance of hematuria, 4 plus albumin, and casts in the urine herald the toxic, or hemorrhagic, phase which usually lasts through the tenth to the fourteenth day.

Abdominal pain and lumbar ache increase and protracted vomiting sets in. Distressing hiccups, severe cough, hemoptysis, and dyspnea are common. Bloody vomitus is frequent and diarrhea likely to be hemorrhagic. Disorientation may be followed by convulsions and delirium.

Numerous petechiae and ecchymoses are evident in the skin. The enlarged lymph nodes are now tender. Signs of pulmonary en-

gorgement as well as cardiac dilation and myocardial failure may be obvious. Urinary excretion decreases, sometimes to the point of anuria.

The white blood count is from 30,000 to 40,000. Atypical lymphocytes are present, and occasionally eosinophils appear in small numbers. The sedimentation rate increases sharply, and platelet counts and bleeding time revert to normal values. The urine, which has shown albuminuria and hematuria, is now cleared and excreted in scanty amounts and with a low specific gravity. An increase in the blood nonprotein nitrogen and creatinine is accompanied by a moderate decrease in blood chlorides and carbon-dioxide combining power.

CONVALESCENCE

During the three- to six-week convalescent phase, the symptoms and hemorrhagic phenomena disappear fairly rapidly and laboratory determinations are once more within normal limits.

The mortality rate is approximately 7%. Residual effects or recurrences are not reported among those who survive. Specific therapy has not yet been determined.

TRANSIENT CRAMPS may occur in the arms and legs of some cardiac patients a few hours after injection of an organic mercurial diuretic. The number of spasms increases with the amount of fluid lost. Walter Modell, M.D., of Cornell University, New York City, believes that the cramps may result from temporary depletion of sodium chloride. Reactions may be reduced or eliminated by giving small, frequent doses that confine fluid loss to less than 2 lb., preferably about 1½ lb., after each injection.

New York State J. Med. 53:211-214, 1953.

*Surgery for arteriosclerosis
with vasospasm and potentially elastic vascular
bed may be helpful.*



Sympathectomy for Arteriosclerosis

LOUIS T. PALUMBO, M.D., LLOYD F. QUIRIN, M.D.
AND RUSSELL W. CONKLING, M.D.

Veterans Administration Hospital, Des Moines

IN selected cases, lumbar sympathectomy is effective in treatment of patients with arteriosclerosis of the lower extremities.

The value of this operation, state Louis T. Palumbo, M.D., Lloyd F. Quirin, M.D., and Russell W. Conkling, M.D., is based upon the release of vasospasm of the vascular channels, particularly the vascular bed. The unaffected collateral channels can develop to the fullest extent. The peripheral circulation is usually considerably improved, thereby eliminating or decreasing pain, increasing warmth and dryness of the affected extremity, and speeding healing of ulcers and subsidence of cellulitis and edema.

When amputation becomes necessary, the stump heals more rapidly after sympathectomy. In many instances the amputation can be accomplished at a lower level than formerly advocated.

A trial of procaine lumbar sympathetic blocks preoperatively is a good index to the outcome of sympathectomy. Elevation of temperature of the extremity, readily detected by the examining hand, as well as dryness of skin, decrease or elimination of pain, and increases of walking distance without pain or

Lumbar sympathectomy for peripheral arteriosclerosis. Ann. Surg. 137:61-66, 1953.

discomfort are all excellent criteria that considerable vasospasm existed and that the collateral vascular bed has elastic potentialities. These signs are a favorable omen of good to excellent results from sympathectomy. The effects obtained by surgery will usually exceed the benefits achieved by blocks, since a thorough operation is a more accurate method of interrupting all the sympathetic pathways.

Spinal anesthesia is employed for the surgical procedure. A transverse abdominal incision is made at the level of the umbilicus. The approach is extraperitoneal through a muscle-splitting incision; the sympathetic ganglionated chain is removed from below the first lumbar ganglion to below the fourth. A variety of patterns of size, number of ganglia, and branches originating from this portion of the chain are seen.

Postoperative complications are not common but include ileus, embolus, neuritis, and phlebitis. The mortality rate for the procedure is about 2%.

Favorable results are apparent shortly after surgery and, in many cases, the improvement in circulation continues for months there-

SURGERY

after. This delay in benefit probably can be explained by the time required for the collateral channels to develop to the fullest extent. Any slight increase of the arterial supply to an extremity or digit brings considerable relief of pain and enhances the healing power of the local tissues, thereby diminishing local infections and cellulitis.

Old age does not interdict surgery. If selection of patients were limited by age, many individuals would be eliminated who might benefit from this type of operation.

Improvement is obtained by lumbar sympathectomy for 88% of patients with peripheral arteriosclerosis. Results are excellent to good for 61%.

Zinc Peroxide for Surgical Infections

FRANK LAMONT MELENEY, M.D.

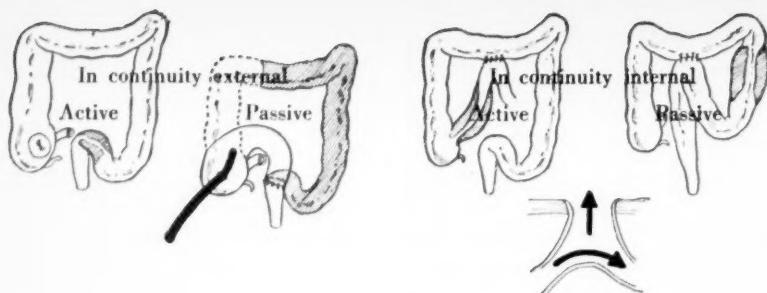
MEDICINAL zinc peroxide is more valuable in the treatment of some types of surgical infections than are the sulfonamides or antibiotics. The drug is particularly useful for lesions of the skin and alimentary tract.

A thick creamy suspension of zinc peroxide on cotton or fine mesh gauze must closely contact the infected surfaces, and the bandage must be kept wet. Therapy for the interior of the body is possible only if cavities have openings from which the residue can be readily removed.

An active, medicinal grade should be used. Effectiveness is enhanced if the powder is activated and sterilized by heating in a dry oven at 140° C. for four hours.

Frank Lamont Meleney, M.D., of Columbia University, New York City, lists the following conditions, in many of which the offending organism is a microaerophilic nonhemolytic *Streptococcus* or *Staphylococcus aureus*, as most suitable for medicinal zinc peroxide treatment: undermining burrowing ulcers; progressive bacterial synergistic gangrene resistant to penicillin and bacitracin; decubital ulcers; gangrenous lesions of the extremities in diabetes and arteriosclerosis; poison ivy; pain and vesiculation of herpes zoster; radio-necrosis of the skin; putrid lung abscesses; human bites; mouth and throat lesions, including ulcerative stomatitis, Vincent's infection of the mouth and gums, and hemolytic *Streptococcus* sore throat; foul-smelling abscesses in the mediastinum or pleura after perforation of the esophagus; plastic oral operations or dental extractions; ulcerative colitis, in retention enemas; and anorectal and nonvenereal vaginal infections.

Present role of zinc peroxide in treatment of surgical infections. J.A.M.A. 149:1450-1453, 1952.



Anatomic and Functional Colostomies

MANUEL E. LICHTENSTEIN, M.D.

Northwestern University, Chicago

CLASSIFICATION

Colostomy in continuity

External decompression

- 1] Active
- 2] Passive

Internal decompression

- 1] Active
- 2] Passive

Colostomy in discontinuity

External

Internal

Colostomy with spur

With bowel resection

Without bowel resection

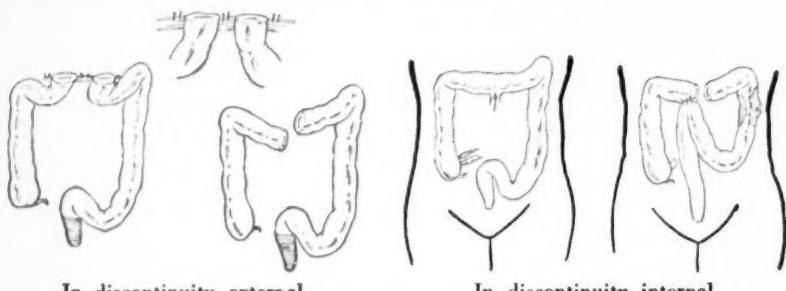
Colostomy on end

NECESSITY, circumstances, and purpose determine the colostomy constructed for an individual.

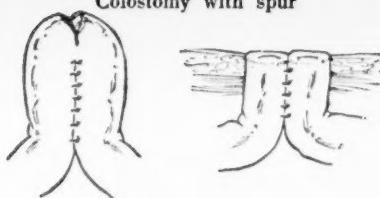
Manuel E. Lichtenstein, M.D., emphasizes that the type selected should provide the greatest usefulness or serve the condition with the least prospect of unnecessary disability.

Colostomy in continuity is used for decompression of the bowel without complete diversion of the fecal stream. When exploration of a greatly distended abdomen for acute colon obstruction is hazardous and the risk of cecal perforation

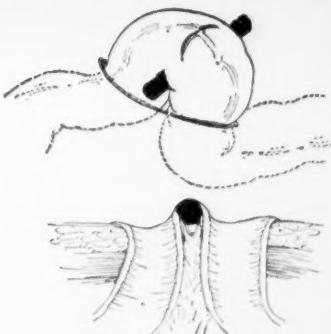
Colostomy. Quart. Bull., Northwestern Univ. M. School 27:44-53, 1953.



Colostomy with spur



Spur without bowel resection



tion is likely, active external decompression—cecostomy—will collapse the bowel with the least risk. The cecostomy does not interfere mechanically with extensive resection of the left colon.

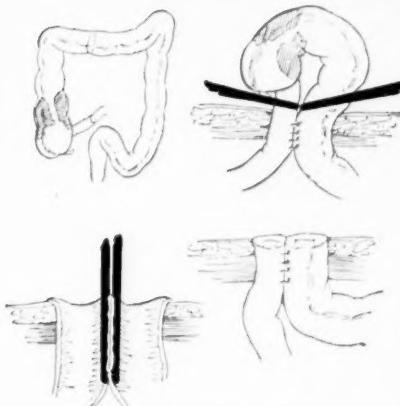
When an anastomosis is made in a colon that is not fully decompressed or completely free from edema, a tube in the cecum may prevent further distention and permit complete subsidence of the local process—passive external decompression. Recent methods of bowel preparation before operation and of postoperative care have made this type of colostomy relatively obsolete.

Active internal decompression—ileocolostomy, colocolostomy—does not completely sidetrack the fecal

current but does decompress the bowel proximal to the obstruction. The distal colon receives the excess pressure from the obstruction.

With no obstruction, an internal colostomy—passive internal decompression—is sometimes desirable to avoid impending obstruction or to permit healing in an inflamed bowel segment. Complete diversion of the fecal stream is usually not achieved.

Colostomy in discontinuity is done to divert the fecal stream completely with defunctionalization of the distal colon. The external type is used when extensive malignant metastasis precludes any possibility of excision or when extensive injury or disease is found



Spur with bowel resection



Colostomy on end

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in the distal bowel. The patient is relieved of the distress occasioned by bathing of the ulcerated lesion in fecal matter, total bowel obstruction is prevented, and any distal inflammatory process is allowed to heal. Sufficient bowel and mesentery are required to exteriorize the entire segment without tension.

The internal type is used when the fecal stream must be completely diverted to allow healing of a fistula from an inflammatory mass in a segment of the colon.

Colostomy with spur may be constructed incidentally to resection of an exteriorized segment of bowel in cases of volvulus, trauma, inflammatory disease, strangulation, or some types of carcinoma. Later the spur is crushed and allowed to slough, converting the opening into a colostomy in continuity. The colostomy may be closed when circumstances permit.

When a colostomy with spur but without bowel resection is done, a loop of colon is brought up through the abdominal wall and suspended by a rod or tube placed through a

mesenteric opening. The procedure is more readily done on transverse or sigmoid colon which is not greatly distended and can be manipulated safely. The bowel must first be adequately mobilized.

The colostomy may be opened immediately and a catheter inserted, or the bowel may be incised transversely after adhesions seal the colon to the abdominal wall. After opening, the incised longitudinal fibers retract, exposing proximal and distal lumens. Closure of the transverse slit restores continuity.

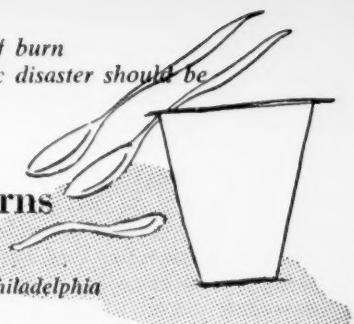
For rectal injuries, a loop of normal proximal colon may be exteriorized, the proximal and distal limbs sewn together, and the protruding bowel sectioned at the apex. Closure of the double-barreled colostomy is effected by crushing the spur.

Colostomy on end is an artificial anus placed on the abdominal wall after complete excision of the left colon or rectum and the natural anus. A perineal on-end colostomy is not desirable since pus cannot be controlled at this location.

¶ SIGMOIDOSCOPY is facilitated when leg troughs are used to hold the patient in a modified knee-chest position with knees widely separated and legs acutely flexed. The device designed by Lyman C. Blair, M.D., of Houston consists of 2 tapered trough-like pieces of 16-gauge stainless steel welded together at a 30° angle, reinforced at the bottom with a yoke of heavier steel, and supported on a swivel attached to a $\frac{5}{8}$ -in. S-shaped steel rod. The paired accessories are mounted in the stirrup sockets of examining or operating tables. Advantages are increased relaxation and working space, avoidance of external pressure on the abdomen, and a tendency of the viscera to roll cephalad. The apparatus should not be used for patients with low cardiac or respiratory reserve.

Surg., Gynec. & Obst. 96:249-250, 1953.

Plans for emergency care of burn casualties in event of atomic disaster should be realistically conceived.



Mass Treatment of Burns

JONATHAN E. RHOADS, M.D.

University of Pennsylvania, Philadelphia

ESTIMATES on the types and numbers of casualties that might result from an atomic bomb detonation are based on the Japanese experience. In considering the care of the victims, the realist must recognize that most of the initial therapy will not be performed by doctors or others trained in first aid.

Plans for such a disaster, explains Jonathan E. Rhoads, M.D., must include [1] oral sodium chloride and sodium bicarbonate solution for most of the casualties, plus blood and plasma or plasma substitutes for the minority who will benefit the most from such transfusions, [2] both closed and open local treatment, especially the former, [3] an early and vigorous feeding program, and [4] centers for late debridement and grafting procedures.

A bomb similar to those used at Hiroshima or Nagasaki, detonated at an elevation of 2,000 ft. over a large city, would probably exert severe effects over a radius occupied by 300,000 to 400,000 people. Many minor injuries would be sustained at greater distances. Of the people injured, 60% or more would have thermal burns; about 25% would have mechanical injuries; and 10 or 15% would have

injuries from ionizing radiation. The casualties sustained in Japan may be vastly exceeded in some future conflict.

To supply the best known treatment for burns, whole blood and plasma or both should be given in sufficient quantities to restore and maintain peripheral circulation and to keep the hematocrit under 55. Ideally, for each 1% of body area burned, 1 cc. of an electrolyte solution and 1 cc. of blood or plasma or both per kilogram of body weight should be given. The electrolyte solution is composed of 1 part Ringer's lactate solution and 2 parts 0.9% sodium chloride solution. In addition, sufficient 5% glucose in water is needed to compensate for insensible loss. Approximately half of these amounts are required during the second twenty-four hours; after this, normal intake of fluid and large amounts of food are recommended.

The available blood and plasma in a bombed area would probably provide for no more than a fraction of 1% of the need. Plasma substitutes are being studied, but these require intravenous administration and thus would be subject to the limitations of equipment and personnel. Therefore, oral adminis-

Mass treatment of burns. Pennsylvania M. J. 56:191-194, 1953.

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tration of single electrolyte solutions may be necessary.

When oral therapy has to be used, the procedure should be started early. For all but minor burns a solution of sodium chloride, 2 level teaspoonfuls, and baking soda, 1 level teaspoonful, in 3 pt. of potable water should be administered at the rate of 1 or 2 glasses an hour for at least twenty-four hours.

The open method of burn treatment has the following advantages: early disappearance of pain, avoidance of painful dressings, early development of a dry eschar, facilitation of rapid ambulation, and least damage to epithelial remnants.

However, the open method requires an insect-free environment,

is not suitable for burns of the hands or circumferential burns of the trunk, and is not well adapted for transportation of patients. Infections occur at the edges of the burn, necessitating daily dressings for these areas.

For mass casualties, therefore, a closed method of therapy is best. Dressings with either no debridement, or a very superficial one, are recommended. Pressure dressings should not be applied by inexperienced persons. Appropriate tetanus prophylaxis should be used and antibiotics given in moderate doses.

Centers for treatment of burned patients would have to be established and personnel provided.

A high-protein diet should be started as early as possible.

Postoperative Volvulus of the Cecum

GEORGE L. JORDAN, JR., M.D., AND OLIVER H. BEAHRIS, M.D.

A POSSIBLE, though extremely rare, cause of postoperative intestinal obstruction is cecal volvulus. The condition may be diagnosed from the history and the appearance of gas-filled loops on simple roentgenograms of the abdomen.

George L. Jordan, Jr., M.D., and Oliver H. Beahrs, M.D., of Mayo Clinic, Rochester, Minn., note that acute volvulus of the cecum occurs only once in about every 25,500 abdominal operations. Hence the chance of production of a volvulus during operation is extremely small, especially if the intestine is carefully handled. Volvulus may also be chronic or recurrent and unrelated to the surgery.

Since gangrene may occur within hours, operation should be performed immediately in cases of acute volvulus of the cecum. If gangrene is not evident, detorsion of the intestine and fixation of the bowel to the lateral abdominal wall are done. If the intestine is gangrenous, primary resection and anastomosis should be employed unless the patient's condition is too critical to tolerate this procedure. Volvulus of the cecum as a postoperative complication. *Ann. Surg.* 137:245-249, 1953.

*Technical difficulties of 1-stage
abdominoperineal surgery are lessened by using
2 operating teams.*

Two-Team Resection of the Rectum

W. B. NEAL, JR., M.D., E. R. WOODWARD, M.D.,
A. E. KARK, M.B., P. V. HARPER, JR., M.D.,
AND L. R. DRAGSTEDT, M.D.

University of Chicago

THE large, widely invasive, or fixed rectal carcinoma is frequently difficult to remove, even by a prolonged procedure, if a conventional single-team operation is performed.

Excision of the rectum by two groups operating simultaneously saves time, gives better exposure, permits better cancer surgery, allows more accurate closure of the pelvic floor, and eliminates undue shock, report W. B. Neal, Jr., M.D., E. R. Woodward, M.D., A. E. Kark, M.B., P. V. Harper, Jr., M.D., and L. R. Dragstedt, M.D.

The patient is placed in a modified lithotomy position, with the legs widely abducted but only partially flexed at the hip and knee. The sacrum is elevated, and the table put in moderate Trendelenburg position. A long midline incision is made from the pubis to the left of the umbilicus, then on to the left costal margin.

After manual exploration of the abdomen, the left hemicolon is mobilized and the inferior mesenteric artery and vein are ligated and divided high. Another team then begins the perineal dissection.

Abdominoperineal resection of the rectum by 1953.

The coccyx is disarticulated and excised, and the levator ani muscles are divided between clamps and ligated.

The two teams dissect toward each other, cooperating in identifying fascial planes and pelvic structures. Extensive radical dissection can be done, as all important structures and the obturator fossae are directly in view.

When the rectum has been freed, the anus is enclosed in a rubber glove and the pelvic colon is delivered into the abdomen. The abdominal team closes the pelvic floor while the perineal team introduces a pelvic pack to support the floor accurately. The perineal wound is closed loosely about the pack with interrupted sutures.

The patient is then taken out of Trendelenburg position. The transverse colon is divided, allowing removal of the specimen. A colostomy is constructed through a stab wound in the midline, halfway between the xiphoid and the umbilicus.

Unnecessary shock is prevented by delaying the perineal dissection until the inferior mesenteric artery

the two-team technic. Ann. Surg. 137:325-328, 1953.

SURGERY

is ligated, by doing a meticulously hemostatic perineal dissection from below, and by starting blood transfusions early.

The left hemicolecotomy allows

wide en bloc resection of lymph-bearing tissue, removes any proximal neoplastic lesions, and obviates left gutter herniation and colon necrosis from tension.

Pulmonary Resection for Tuberculosis

JAMES D. MURPHY, M.D., AND BARNEY B. BECKER, M.D.

THE combined use of streptomycin and pulmonary resection has much value in treatment of tuberculosis.

Studies of 100 cases three to six years after operation show that pulmonary resection can now be done with reasonable morbidity and low mortality, observe James D. Murphy, M.D., of Veterans Administration Hospital, Oteen, N. C., and Barney B. Becker, M.D., of Marquette University, Milwaukee. Before the use of streptomycin, the operation entailed a high incidence of complications such as empyema, spread of disease, and bronchopleural fistulas.

Indications for pneumonectomy, in order of importance, are thoracoplasty failure, extensive unilateral disease, destroyed lung, tuberculous bronchiectasis, failure of conservative collapse measures, and tuberculous empyema with nonexpansile lung; for lobectomy: thoracoplasty failure, elective procedure, failure of conservative measures, tuberculous bronchiectasis, hydropneumothorax with unexpanded lung, undiagnosed lesion, lower lobe cavity unresponsive to conservative therapy, recurrent cavity, and bronchostenosis.

The mortality rate for pulmonary resection is about 9%. The principal causes of death are operative hemorrhage, tuberculous pericarditis with tamponade, meningitis, pulmonary edema, embolism, and cardiac arrest.

The most important early complication is bronchopleural fistula; of importance also are empyema, pneumonitis, spread of the disease, reactivation, and extrapulmonary tuberculosis. Early complications are fewer after lobectomy.

Of the patients who had pneumonectomies, 90%, and of those who had lobectomies, 55%, have sputa free of tubercle bacilli since operation.

Careful case selection and long-term chemotherapy before and after surgery are necessary. The lesion should be stabilized before surgery. Streptomycin is continued at least sixty days after the operation.

Intermediary report of 102 streptomycin-protected pulmonary resections. Am. Rev. Tuberc. 67:22-28, 1953.

*Exaggerated publicity threatens
to discredit the potentially useful discipline of
natural childbirth.*

Natural Childbirth?

ARTHUR J. MANDY, M.D., THEODORE E. MANDY, M.D.,
ROBERT FARKAS, M.D., AND ERNEST SCHER, M.D.
Sinai Hospital, Baltimore

THE benefits claimed for natural childbirth are primarily psychologic. By dramatically calling attention to the emotional needs of the expectant mother, Grantly Dick Read has made a lasting contribution.

Because of this new concept, several questions are raised: Is pain in childbirth a culturally induced phenomenon? Must patients actively participate in the delivery? Are expectant mothers entitled to the benefits of modern anesthesia and analgesia? Is psychologic damage likely to either mother or child if the mother is delivered in a state of unconsciousness?

Arthur J. Mandy, M.D., Theodore E. Mandy, M.D., Robert Farkas, M.D., and Ernest Scher, M.D., as a result of a three-year study, reach some preliminary conclusions which differ somewhat from those reported by enthusiastic advocates of natural childbirth.

The program of natural childbirth consists of four major issues—diet, education, exercise, and relaxation.

Diet apparently has a negligible influence on labor except in conditions of extreme deprivation. Education removes some of the taboos. Is natural childbirth natural? *Psychosom. Med.* 14:431-438, 1952.

surrounding pregnancy and childbirth, but too intensive instruction in anatomy and physiology may arouse apprehension. Exercises are difficult to evaluate but are probably of little advantage.

However, the increased personal attention and group participation and the competition involved often make the first three factors beneficial to the patient. Relaxation techniques are closely akin to hypnosis.

Good patient-doctor and patient-hospital relationships are fundamental to the success of a natural childbirth program. Harsh treatment or discipline or frustrated or sadistic attendants must not be allowed. Thus the negative conditioning in pregnancy is replaced with a positive one.

Even in such an environment, supplements of analgesia and anesthesia must be added according to the individual's needs. These are necessary agents because childbirth is seldom free of discomfort and emotional conflicts may disturb uterine physiology. Such conflicts may have nothing to do with the actual childbirth but be related to fears of increased responsibility, loss of personal freedom and com-

panionship, economic deprivation, and inadequate housing.

Anesthesia permits unhurried, meticulous care at the delivery table which no other technic provides.

Natural childbirth is not a panacea for the emotional problems of either the mother or offspring. The method is useful for mothers who need personal attention and moral support, but is inadequate for seriously disturbed women.

With increased emotional support, the analgesic drug requirements can be reduced to safer levels.

The emphasis that any *normal* woman can be delivered by natural childbirth tends to stigmatize those who fail to participate.

Although natural childbirth has many good features, the entire program is in danger of being discredited because of the exaggerated claims made.

Blood Loss During Gynecologic Operations

MYRON I. BUCHMAN, M.D.

BLEEDING in gynecologic surgery is much greater than generally realized.

In the New York Lying-In Hospital, New York City, average blood loss during abdominal hysterectomy is 678 cc.; anterior and posterior repair, 556 cc.; Manchester plastic technic, 849 cc.; vaginal hysterectomy, 716 cc.; and Wertheim operation for cervical cancer, 2,340 cc.

Myron I. Buchman, M.D., of Cornell University, New York City, measures volume by the simple gravimetric procedure. A dietitian's scale is adequate to weigh collected free blood and soaked sponges or drapes.

In abdominal hysterectomy, amounts will increase with the patient's weight and the length of operation but are not affected by age or tumor size.

Blood loss during vaginal plastic repair is relatively greater in young women and with long procedures, up to but not beyond a maximum period of two hours. Weight and degree of vaginal relaxation are not factors.

Transverse and midline abdominal incisions cause approximately equal amounts of bleeding.

A large postoperative blood deficit exceeding 12% of the total volume, using Randall's figures based on body weight, can be determined with reasonable accuracy by hematocrit on the third day. For smaller losses the method is unreliable.

Blood loss during gynecological operations. Am. J. Obst. & Gynec. 65:53-64, 1953.

*Recognition of vulvar carcinoma
in the preinvasive phase greatly improves chances
of successful removal.*

Intraepithelial Cancer of Vulva

SPRAGUE H. GARDINER, M.D., FRANCIS E. STOUT, M.D.,
J. L. ARBOGAST, M.D., AND CARL P. HUBER, M.D.
Indiana University, Indianapolis

INVASIVE carcinoma of the vulva is apparently preceded by an intraepithelial phase. Recognition of the malignant growth during this preinvasive stage may be a great help in reducing the mortality now associated with this lesion.

Sprague H. Gardiner, M.D., Francis E. Stout, M.D., J. L. Arbo gast, M.D., and Carl P. Huber, M.D., cite cases to show that the preinvasive stage may exist from seven to eleven years before invasion occurs. Ages varied from 29 to 78 years in a group studied and all had borne children.

The diagnosis of preinvasive cancer of the vulva rests upon the physician's awareness of the possibility, recognition of the appearance of the gross lesion, and an adequate biopsy, which includes the periphery of the lesion and the adjoining normal skin.

The patient usually describes vulvar itching and burning of the vulva on urination. Generally, a small lump on the vulva is noted early. Pain, bleeding, and discharge are not common.

Intraepithelial carcinoma usually appears grossly as a reddened, velvety, flat or slightly elevated, well-delineated lesion on the vulva.

Intraepithelial carcinoma of the vulva. Am. J. Obst. & Gynec. 65:539-549, 1953.

Many small growths may be visible rather than one large one. No crusting, weeping, or bleeding is seen at this stage. Invasion is suggested by signs of nodulation or ulceration in the center of the lesion.

In microscopic studies of intraepithelial cancer, the normal stratification or polarity of the epithelial cells is lacking, as is the usual progressive maturation from the basal cells outward. Under high-power magnification, the cells appear undifferentiated. The epithelial cells and nuclei vary considerably in size and shape, the latter showing deep staining. Numerous mitotic figures, some abnormal, are found.

If invasion occurs, the malignant cells remain anaplastic both in the local invasion and in the lymph node metastases.

Preinvasive cancer must be differentiated from Paget's disease, Bowen's disease, arsenic dermatitis, radiation dermatitis, inflammatory acanthosis, and leukoplakia. A careful history together with the biopsy should make the differentiation. The patient should be questioned about previous skin disease or arsenic or roentgen treatment to the vulva.

When intraepithelial cancer has

been demonstrated microscopically, complete vulvectomy should be done. With invasion, inguinal nodes should be resected. Inguinal node dissection may not be needed if, after careful multiple block microscopic study, the entire lesion is found to be an exclusively intraepithelial carcinoma.

A high incidence of cervical cancer is associated with carcinoma of the vulva. This is probably an indication of biologic sensitivity to neoplastic disease in these individuals, since careful histologic study has failed to reveal a metastatic origin of the vulvar lesions.

Irregular Endometrial Shedding

CHARLES E. MC LENNAN, M.D.

PROLONGED or irregular endometrial shedding is typically a regularly recurring menorrhagia in which the bleeding phase of the menstrual cycle requires one to two weeks for completion, without subsequent prolongation of the cycle. Diagnosis is made by recovering retained secretory endometrium five or more days after onset of menstrual bleeding, states Charles E. McLennan, M.D., of Stanford University, San Francisco.

The difficulty occurs throughout the childbearing age, being uncommon in adolescents or menopausal women. The etiology is obscure although definitely related to persistence of corpus luteum activity well into the bleeding phase of the cycle.

No definite duration or amount of bleeding is characteristic; one week of bleeding is the shortest time consistent with a diagnosis of irregular shedding, but the flow usually lasts somewhat longer. The total length of the cycle customarily does not change. An appreciable increase in the quantity of bleeding occurs, being most noticeable on the second and third days. Many patients have to wear 2 perineal pads simultaneously, whereas 1 was adequate previously.

Associated lesions such as myoma or endometrial polyps may be found but cannot be considered responsible for the irregular shedding syndrome.

Dilatation and curettage is successful treatment for most patients. Sometimes further treatment is required because of persistence or recurrence. Roentgen sterilization is only occasionally a satisfactory solution since many of these patients are young. Hormonal therapy has been advised but not yet adequately evaluated. Hysterectomy must be resorted to for persistent cases unsuccessfully treated by any other means.

Current concepts of prolonged or irregular endometrial shedding. *Am. J. Obst. & Gynec.* 64:988-998, 1952.

*Hernia and evisceration may
be prevented by postoperative exploration if wound
complication seems likely.*

Abdominal Wound Complications

GEORGE F. SUSTENDAL, M.D., AND CONRAD G. COLLINS, M.D.
Tulane University of Louisiana, New Orleans

AFTER obstetric or gynecologic surgery, exploration should be done promptly if a wound complication is suspected. Investigation is important for any wound that shows unusual fluctuation, induration, purulent, bloody, or serosanguineous discharge, or tenderness.

When a hematoma, abscess, seroma, dehiscence, or evisceration—alone or in combination—seems likely, the exploration should be done in the operating room, where facilities for the control of hemorrhage and the performance of any operation are available, not in the patient's room or ward, emphasize George F. Sustendal, M.D., and Conrad G. Collins, M.D.

When such precautions are taken, massive evisceration with large amounts of protruding omentum or bowel, and a long interval between occurrence and repair, may be prevented and death averted. Disruption of the wound involving the fascial layers, even though the peritoneum is intact, provides a fertile field for incisional hernias.

In the operating room, the skin is prepared for laparotomy and the suture or sutures are removed and the wound explored. Any abscesses, seromas, and hematomas are thor-

oughly evacuated. The integrity of the facial suture line is inspected. If the continuity of the fascia is disrupted, sutures are removed and the line of suture in the peritoneum explored. Any defects in the peritoneum or fascia are repaired.

General factors are of importance in wound disruption. Lack of proper nutrition, with consequent anemia, low serum protein, and avitaminosis, is a contributing factor. Malignant disease will also predispose to wound complications.

Evisceration occurs most commonly after midline longitudinal incisions which, however, are used much more commonly than paramedian or transverse incisions in gynecologic operations. The use of interrupted nonabsorbable suture does not prevent evisceration. Increased intraabdominal pressure should be avoided.

The average time of wound exploration is seven days postoperatively, or about the time the sutures would normally be removed and the wound inspected. Through-and-through sutures are usually used for wound resuturing in the form of a mattress or a figure-of-8 suture. Wound infections are packed open and resutured later.

Abdominal wound complications in obstetric and gynecologic surgery. *Obst. & Gynec.* 1:263-268, 1953.

*Management of uterine inertia
may be improved with safety by judicious use of
Pitocin infusions.*

Intravenous Pitocin in Labor

RAYMOND H. KAUFMAN, M.D., STANLEY M.
MENDELOWITZ, M.D., AND WILFRED J. RATZAN, M.D.
Beth Israel Hospital, New York City

EXCELLENT results in induction of labor and treatment of uterine inertia may be obtained with intravenous administration of Pitocin by dilute infusion. When properly controlled, the procedure is a safe and efficient means of stimulating labor.

When the intravenous, rather than intramuscular or intranasal, route is used, the uterus works in a more regular and physiologic manner because the amount of drug in the circulation at any one time is constant and easily regulated by adjustment of the rate of flow or dilution. Use by prolonged intravenous drip during labor does not affect the blood pressure or pulse of the mother.

Raymond H. Kaufman, M.D., Stanley M. Mendelowitz, M.D., and Wilfred J. Ratzan, M.D., use Pitocin instead of Pituitrin in order to avoid the vasospastic effect of Pituitrin on the coronary arteries as well as the vasopressor effects of the latter drug and to obviate the simultaneous use of cyclopropane anesthesia and Pituitrin.

A dilution of 7½ minimis of Pitocin in 500 cc. of 5% glucose in water or saline, 1:1,000 dilution, is satisfactory. After the infusion

is running at the rate of 10 to 12 drops per minute, Pitocin is added and thoroughly mixed. A more rapid rate at the start may cause tetanic uterine contractions.

In about thirty minutes the speed is gradually increased to 20 to 30 drops per minute. If contractions are only weak and irregular, the infusion may run as fast as 60 to 80 drops per minute but if response is not obtained by a slow drip, an increase in rate of flow is usually not much more effective.

The drip should run continuously until well after the end of the third stage of labor. Postpartum uterine atony is twice as frequent when the infusions are prematurely discontinued. Immediately after delivery the rate is increased to 60 to 100 drops per minute.

During the entire administration, the fetal heart beat should be carefully observed, especially during the first hour. The heart beat occasionally slows because of persistent increase of uterine tone. This condition may be corrected by discontinuing the infusion until at least twenty to thirty minutes after the heart rate returns to normal.

Intravenous Pitocin infusion in labor. Am. J. Obst. & Gynec. 65:269-277, 1953.

Important considerations in inducing labor are the ripeness of the cervix and rupture of the membranes. When the cervix is soft, thin, completely effaced, located anteriorly, and dilated at least 2 cm., failure of induction is rare. Labor is more rapidly induced when the membranes rupture. Persistent use of Pitocin will cause some of these patients with unprepared cervices to go into labor, but

use in this fashion is not recommended.

Pitocin must not be employed in the presence of cephalopelvic disproportion, abnormal presentation, placenta previa, and lack of progress in dilatation and descent despite good contractions, or for patients of numerous parity. Continued use of the drip in cases of unresponsive uterine inertia is dangerous.

Testosterone for Cancer of the Cervix

JOHN BARKLEY GRAHAM, M.D., AND RUTH M. GRAHAM

TESTOSTERONE propionate may prove useful in enhancing the effectiveness of radiation therapy for patients with cancer of the uterine cervix.

Many patients who seemingly should respond to conventional radiation therapy fail to do so. Undetected metastases or resistant tumors are usually cited as reasons. John Barkley Graham, M.D., and Ruth M. Graham of Harvard University, Boston, postulate that the patient, as well as the tumor, may be radioresistant.

Examination of the vaginal smear during or immediately after radiation may reveal which patients will have poor results from therapy with radiation. Some of the nonmalignant epithelial cells will show cytoplasmic vacuolization, increase in cell size, and multiple nuclei. When over 75% of the nonmalignant cells have such changes, good effect from radiation can be expected. If such alterations are found in less than 65% of nonmalignant cells, the patient will probably not benefit from radiation therapy.

Testosterone propionate will alter this poor cellular response in some cases. The dosage used is 25 mg. every other day for an average total dosage of about 525 mg. Doses of 100 mg. of alphacopherol per day during the radiation therapy period produce the same type of altered cellular response.

Whether the cellular response to radiation will be accompanied by a correspondingly improved cure rate only time can tell. Considering the uniformly poor outlook for these patients, even a short survival rate would represent an improvement.

A method of enhancing the effectiveness of radiotherapy in cancer of the uterine cervix. *Cancer* 6:68-76, 1953.

Antibiotic therapy for symptomatic neurosyphilis is safer, swifter, and more effective than older methods.

Treatment of Neurosyphilis

ROBERT R. KIERLAND, M.D.

Mayo Clinic, Rochester, Minn.

THE administration of penicillin is now considered the best treatment for neurosyphilis. Adjunctive fever therapy is used in some cases. Other antibiotics may be tried in unusual conditions, explains Robert R. Kierland, M.D.

A total dose of at least 6,000,000 units of penicillin over a period of at least ten days is given as a first course. The schedule may be varied. As examples, 600,000 units may be administered daily for ten days; 300,000 units daily for twenty days; or 600,000 units of repository penicillin daily, every other day, twice a week, or even less frequently.

One course is generally adequate. A poor response may indicate the need of a second similar or more intensive course. Only rarely is a third necessary. If two courses of penicillin fail to effect good results, fever therapy, especially malarial, should be considered or another antibiotic, such as aureomycin.

Aureomycin should probably be reserved for patients who are hypersensitive to penicillin or whose disease is resistant to penicillin. Aureomycin in a total dosage of approximately 60 gm., administered as 2 to 4 gm. per day in Neurosyphilis. Minnesota Med. 36:240-243, 246, 1953.

divided doses, yields results equivalent to those achieved by a first course of penicillin. When aureomycin causes gastrointestinal symptoms, continuation of medication may be possible with reduced daily dosage. Terramycin and chloramphenicol are also valuable against neurosyphilis but the latter may cause hematopoietic suppression.

If the patient has optic atrophy or severe paresis, the first course of 6,000,000 units of penicillin should be accompanied by fever therapy.

In the diagnosis of neurosyphilis, clues are furnished by a complete and accurate history, a comprehensive physical examination, including thorough neurologic studies, serologic tests, and examination of the cerebrospinal fluid. Nothing substitutes for a high index of suspicion of the disease before neurologic changes are irreversible as in obvious cases of paresis or locomotor ataxia.

The diagnosis of active neurosyphilis rests primarily upon the finding of abnormalities in the cerebrospinal fluid. In order of importance, these are [1] increased cell count, [2] increased concentration of protein, [3] positive serologic reaction for syphilis, and [4]

abnormal reaction in the colloidal gold test.

Diagnosis of activity is more difficult in cases of vascular neurosyphilis, syphilitic epilepsy, gumma of the brain or spinal cord, eighth nerve deafness, or optic atrophy without paresis, since the spinal fluid may be normal in all these conditions. In many of these cases diagnosis may be made by clinical trial of penicillin with or without fever therapy.

The spinal fluid should be examined four to six months after the completion of treatment. If the increased cell count has reverted to normal or near normal, the amount of protein has decreased, and the patient seems improved, no further treatment is needed. The complement-fixation reaction and results of the colloidal test may

not revert to normal for several months or years and cannot be used to gauge adequate treatment.

Lack of clinical evidence of improvement does not mean that treatment has been ineffective, since many changes may be irreversible and persist without active disease. On the other hand, the patient's symptoms may be ameliorated in spite of continuing active disease.

If, however, the cell count and protein value remain high, a second course of therapy is mandatory. The second course should be the same as, or more intensive than, the first one.

When the response is favorable, the spinal fluid should be examined at intervals of four to six months for the first year after treatment, then yearly until the spinal fluid is no longer abnormal.

Staining Spirochetes

EDWARD T. EMURA, M.D.

A SIMPLE technic for staining spirochetes uses Parker 51 superchrome blue-black ink.

Edward T. Emura, M.D., of the University of Cincinnati reports the use of this procedure concurrently with darkfield examination in 50 cases of infectious syphilis with good correlation.

The method is as follows:

- 1] A drop of serum and a small drop of Parker 51 blue-black ink are placed on one end of a clean glass slide.
- 2] Smearing is done rapidly as in making a blood smear.
- 3] The smear is allowed to dry. This takes about two minutes.
- 4] Examination is done using high dry or oil immersion lens.

The spirochetes stain blue-black against a light blue granular background. Specimens may be kept without change in color for more than twelve months.

Rapid and easy method for staining spirochetes with fountain pen ink. *Arch. Dermat. & Syph.* 67:210-212, 1953.

A technic is described for giving transfusions to small infants and obtaining blood specimens.

Venipuncture of Premature Infants

HANS W. KUNZ, M.D.

New York University, New York City

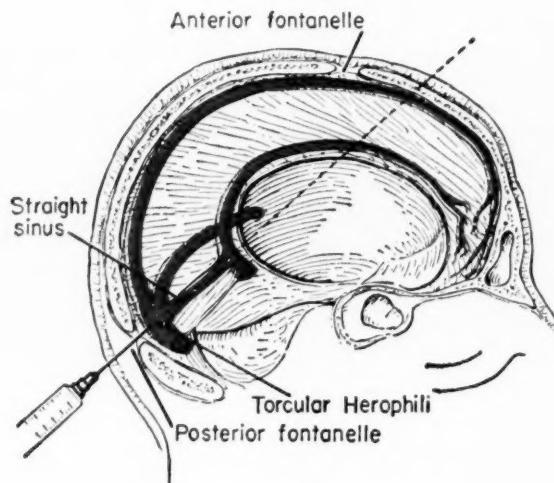
THE torcular Herophili is a safe and convenient site for blood sampling or transfusion of small premature babies.

Directly under the posterior fontanelle, a fairly large reservoir is readily accessible at the junction of the superior sagittal, right and left lateral, occipital, and straight sinuses. The procedure may be done in an isolation unit without removing the infant from an oxygen supply and with little handling of the child.

Hans W. Kunz, M.D., reports more than 100 venipunctures completed without difficulty. From 3 to 5 cc. of blood was obtained from infants weighing less than 1,200 gm. Emergency transfusion was given 2 patients weighing 1 and 1.9 kg.

The child is placed on one side by an assistant and held with back

toward the operator. A 2.5-cm., 20- or 22-gauge needle with short bevel is inserted for 3 or 4 mm.



Direction of needle for venipuncture

into the center of the posterior fontanelle (see illustration).

The point is directed toward the uppermost part of the forehead in the sagittal plane, so that a needle introduced too far will enter the straight sinus without causing injury by perforating any structures.

For transfusion, the needle tip is inserted directly into the straight

A technique for obtaining blood specimens and giving transfusions in small infants. *J. Pediat.* 42:80-82, 1953.

sinus to a point 1 to 1.5 cm. below the skin. To test position, a little blood is aspirated from the sinus just before and at intervals during transfusion.

The injection must be done with the slightest possible pressure. Bleeding is stopped by sterile gauze and finger pressure applied for a minute or two.

Roentgen Hazards in Pediatrics

ROBERT W. MILLER, M.D.

CHILDREN are apparently more likely than adults to have harmful late sequelae from roentgen exposure. Also, the child's longer life span makes delayed changes more possible, especially during the present era of unavoidable exposure to irradiation in industry, medicine, and warfare.

A child's tolerance to irradiation may be dissipated by early roentgen therapy. Therefore, the pediatrician should advise roentgen procedures only for problems which can be solved by no other means. Robert W. Miller, M.D., of the University of Rochester, N. Y., also recommends roentgen exposure diaries.

Films should be used in preference to fluoroscopy for children whenever feasible. A chest film requires only 0.05 r, whereas in fluoroscopy of the chest the patient is exposed to 300 times that dosage.

The ovaries receive 0.2 r each time a film of the abdomen is made. Defects of the germ plasm may be manifest later by increase in abortions, premature births, or infertility, as well as by the appearance of congenital anomalies in offspring.

Irradiation produces premature senility in animals. The possibility exists that the amount of x-rays absorbed by the chest during the diagnostic study of a congenitally defective heart may result in premature aging of the heart, thus impairing the already suboptimal function.

Especially during the early years of life, man can apparently acquire from therapeutic and diagnostic roentgen procedures some of the ingredients of carcinogenesis. Elective use of x-radiation for enlarged thymus, cough of virus pneumonia, acne, and various skin diseases should not be considered unquestionably safe until more is known about roentgen-ray induced diseases.

However, roentgen therapy is justified for treatment of malignant disease in children, though undesirable side effects may appear years later.

Some potential hazards of the use of roentgen rays in pediatrics. *Pediatrics* 11:294-303, 1953.

*Siblings of an infant born
with congenital toxoplasmosis will be free
of the disease.*

Congenital Toxoplasmosis

ALBERT B. SABIN, M.D.

University of Cincinnati

HEINZ EICHENWALD, M.D.

New York Hospital-Cornell Medical Center, New York City

HARRY A. FELDMAN, M.D.

State University of New York, Syracuse

LEON JACOBS, PH.D.

National Institutes of Health, Bethesda, Md.

THE most readily recognized manifestations of human toxoplasmosis result from congenital infection. In the neonatal period such infection is suggested by signs of encephalitis, rash, jaundice, and hepatosplenomegaly, with or without the presence of hydrocephalus, microcephaly, or chorioretinitis.

When an infant has congenital cerebral damage, chorioretinopathy is the most important sign to arouse suspicion of toxoplasmosis as the cause of the brain lesion. Chorioretinopathy is sometimes not apparent at birth but may appear within a few weeks after birth. The macular region is frequently involved, but in some instances the lesions are so far on the periphery of the retina as to be visible only with full dilatation of the pupil and complete fundoscopic examination. This can be achieved for a child only with use of anesthesia.

When the infection is transmitted during early pregnancy, the disease

Present status of clinical manifestations of toxoplasmosis in man. J.A.M.A. 150:1063-1069, 1952.

can develop fully and the infant may be born dead. When transmitted toward the end of pregnancy, the newborn infant may have only the earliest signs of the acute infection, including convulsions, rash, jaundice, and hepatosplenomegaly. In the neonatal period, both chorioretinopathy and cerebral calcification may or may not appear. Hydrocephalus or microcephaly may not occur.

In infancy and childhood, convulsions and psychomotor retardation, with or without hydrocephalus or microcephaly, become the commonest manifestations of congenital toxoplasmosis, but unless chorioretinopathy is demonstrable, the incidence of serologic confirmation of a diagnosis of toxoplasmosis is very low.

Congenital infections can be diagnosed with reasonable certainty by serologic methods. The cytoplasm-modifying or dye test, using methylene blue, for detecting *Toxo-*

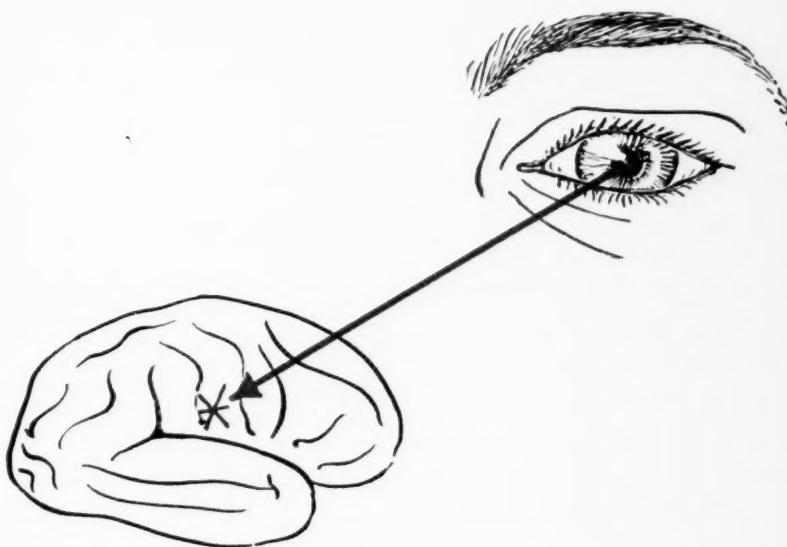
plasma antibodies is recommended for routine purposes by Albert B. Sabin, M.D., Heinz Eichenwald, M.D., Harry A. Feldman, M.D., and Leon Jacobs, Ph.D., in a report of the Committee on Toxoplasmosis of the National Institutes of Health.

The complement fixation test demonstrates whether the infection is recent and active and is appropriate only for children with suspected congenital toxoplasmosis who have high titers by the dye test. A recent and active infection is postulated when the infant's serum has a high titer of dye test antibody, but no complement-fixing antibody, and the mother's serum has high titers of both antibodies.

The chief practical benefit to be derived from a diagnosis of con-

genital toxoplasmosis is the assurance that subsequent children will not have the disease. Other conditions responsible for congenital types of ocular or cerebral damage resembling those with toxoplasmosis carry an uncertain prognosis for subsequent offspring, since many instances of multiple abnormal children in the same family are known. Each of more than 50 mothers who gave birth to 1 child with congenital toxoplasmosis later delivered 1 or more healthy children without the disease.

Specific diagnosis of a recent active infection during the neonatal period warrants the administration of sulfonamides on the basis of the effectiveness of these drugs in animals experimentally infected with *Toxoplasma*.



If full correction is first obtained by plaster, tendon transfer for clubfoot may be of value.

Tendon Transfers for Recurrent Clubfoot

EARNEST B. CARPENTER, M.D., AND SAMUEL H. HUFF, M.D.

*Medical College of Virginia and Crippled Children's Hospital,
Richmond*

INITIAL treatment of talipes equinovarus should be conservative, but 1 or more components will recur in about 10% of cases. Equinus seldom reappears alone.

If surgical therapy becomes necessary, refractory forefoot deviation may be corrected by transfer of the anterior tibial tendon to the base of the fifth metatarsal bone. For inturned heel, medial fibers of the Achilles tendon are fastened to the lateral surface of the os calcis. More likely to fail are operations that attach the anterior tibial tendon to regions other than the fifth metatarsal or shift the posterior tibial tendon to the lateral aspect of the foot, find Ernest B. Carpenter, M.D., and Samuel H. Huff, M.D.

For first treatment of clubfoot, wedging casts are advisable. Any recurrent phase calls for immediate resumption of casts, to prevent fixed bony deformity. Tendons are transplanted only after repeated failure of nonoperative methods.

Since new placement of tendons does not eliminate actual malformation, full correction by plaster must precede orthopedic surgery.

Transfer is done by usual techniques. The anterior tibial tendon is

implanted in a hole drilled in the base of the fifth metatarsal bone. The tendon suture is brought out on the plantar surface and tied over a small button (Fig. 1).

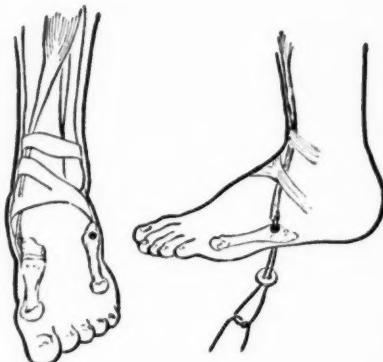


Fig. 1. Transfer of anterior tibial tendon

In the Achilles procedure, medial fibers of the tendon are released, and the tendon is split about 2 in. proximally from the insertion. The free fibers are then rotated posteriorly and sutured to the os calcis near the attachment of lateral Achilles fibers (Fig. 2).

A long leg cast is applied for six weeks. Walking is resumed with either a clubfoot shoe or a cor-

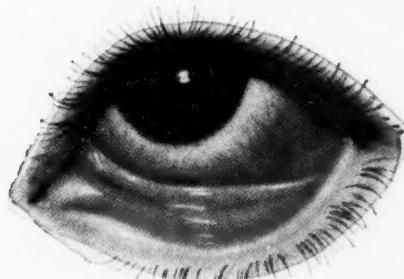
Selective tendon transfers for recurrent clubfoot. *South. M. J.* 46:220-226, 1953.

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References: 1. Brennan, J. W.: Am. J. Ophth. 35:1343 (Sept.) 1952.
2. Pritikin, R. I.: J. Internat. Coll. Surg. 17:234, 1952. — and Duchon, M. L.: Mil. Surgeon 109:706, 1951. — and Farmer, H. S.: Mil. Surgeon 108:309, 1951.

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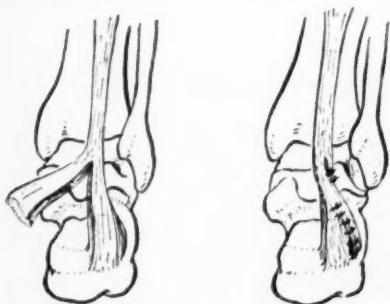


Fig. 2. Transfer of medial fibers of Achilles

To determine the best operative method, 18 instances of tendon transfer performed by several operators were reviewed. Patients were 9 boys and 5 girls, aged 4½ to 9½ years. Club feet were unilateral in 10 cases, bilateral in 4.

In every instance, wedging casts had been employed from the be-

ginning of therapy, and all relapses were managed by reapplication of casts. No previous operations had been done.

The anterior tibial tendon was moved to the lateral side of the foot in 12 cases without other surgery. The same procedure accompanied insertion of the posterior tibial tendon on the lateral aspect of the os calcis in 4 cases. Lateral transplant of medial Achilles fibers on the calcaneus was done twice. No relapse occurred after the surgery in these 2 cases, although Achilles transfer was observed only a year postoperatively.

The anterior tibial tendon was fastened elsewhere than to the fifth metatarsal in 5 instances. Varus deformity returned in 4, once following removal to the lateral cuneiform bone and 3 times after cuboid anchorage. Posterior tibial transplant for os calcis inversion failed in 3 of 4 cases.

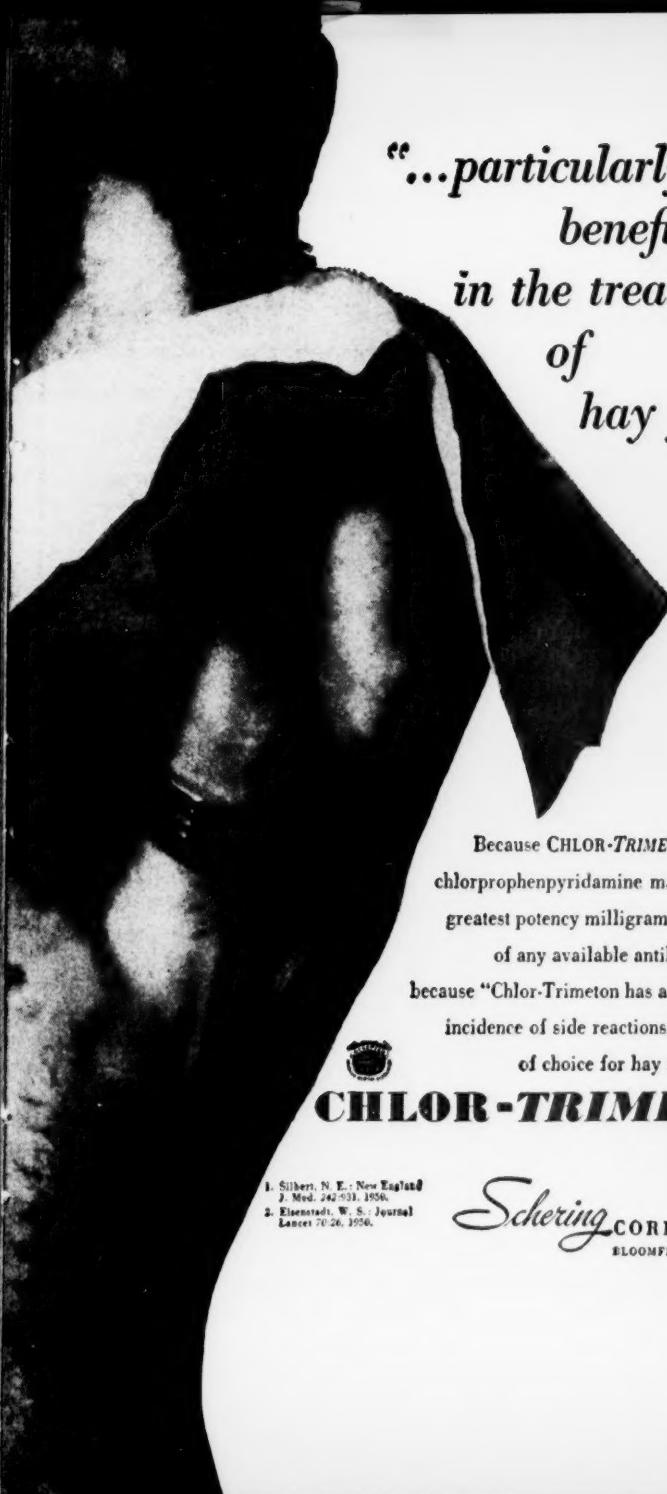
Delayed Urethral Stricture after Trauma

OWEN DANIEL, M.B.

STRICTURE can develop as long as twenty-five years after an apparently trivial injury to the anterior urethra from an accident or from faulty catheterization.

Owen Daniel, M.B., of the Post-graduate Medical School of London, England, who cites 4 cases of traumatic urethral stricture appearing twelve to twenty-five years after the original injury, believes that dilatation for only a year or two after the trauma will probably not prevent such lesions. Hence, the passage of a sound at six-month intervals is necessary during the entire lifetime of the patient to prevent acute retention, kidney damage, or chronic urinary infection.

Delayed traumatic stricture of the anterior urethra. *Brit. J. Urol.* 24:225-228, 1952.



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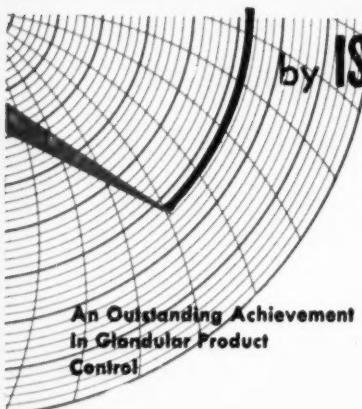
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1. Silbert, N. E.: New England J. Med. 242:531, 1950.

2. Eisenstadt, W. S.: Journal Lester 70:26, 1950.

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Hematuria is important as the earliest symptom of tumor of the bladder and warrants cystoscopic examination.

Urinary Bladder Cancers

MICHAEL K. O'HEERON, M.D., ROY RIDDEL, M.D.,
JAMES BOZZELL, M.D., JACK ROBISON, M.D., AND
ROBERT SATTERLEE, M.D.

*Baylor University, St. Joseph's Infirmary, Methodist Hospital,
and Veterans Administration Hospital, Houston*

CYSTOSCOPIC examination for vesical tumor is indicated in every case of hematuria. The therapy for bladder neoplasms varies with the type of growth, degree of involvement of the bladder wall, multiplicity of tumors, and recurrence.

Bladder carcinomas occur most frequently in men of middle age or older. About 3 times as many men as women are affected.

Local irritation may be an etiologic factor. A transitional cell papillary tumor may form or the normal transitional epithelium may undergo squamous metaplasia followed by squamous cell carcinoma, according to Michael K. O'Heeron, M.D., Roy Riddel, M.D., James Bozell, M.D., Jack Robison, M.D., and Robert Satterlee, M.D.

Papillary tumors with long narrow stalks are usually benign or of a low grade of malignancy and confined to the mucosa. Most non-papillary tumors are highly invasive and are usually found to be infiltrating the muscularis at the time of discovery. The depth of infiltration is often directly proportional to the diameter of the tumor.

Location of the tumor is im-
portant, since those on the trigone,

over a ureteral orifice, or at the internal vesical orifice present complicated anatomic and physiologic problems.

Hematuria is the chief symptom with the majority of vesical neoplasms. In others, medical care is sought because of dysuria, frequency, urgency, stranguria or ureteral pain, or incidental discovery of the tumor.

Treatment of vesical tumors should be instituted with the realization that all are potentially malignant. The benign papilloma probably does exist.

Transurethral resection and fulguration is reserved for obtaining biopsy material, treating single and multiple papillomas of low malignancy and with narrow stalks, and for control of bleeding in some instances. The biopsy is preferably made with a resectoscope. Tissue should be excised from the periphery of the base and from deep in the muscularis beneath the base to determine infiltration.

Multiple papillomas present a technical problem. Probably no

(Continued on page 118)

J. Internat. Coll. Surgeons 19:25-42, 1953.

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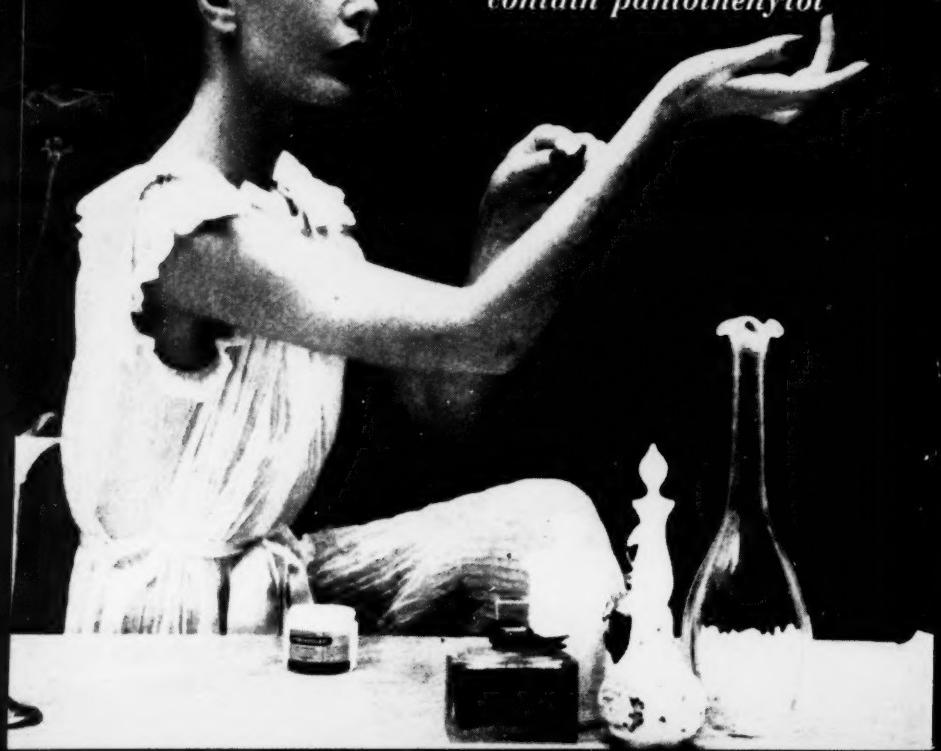
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UROLOGY

more than 15 should be coagulated at one time.

Recurrent papillomas are resected, the base fulgurated, and radon seeds implanted when malignancy and infiltration still appear to be low and if the patient is a poor surgical risk. Radical intervention is required for a pronounced increase in malignancy or for muscular infiltration.

High-voltage roentgen therapy often results in a painful, small, contracted bladder and should be used only as a palliative procedure when operation seems too risky.

Suprapubic cystotomy and fulguration with radium or radon seeds is used for benign papilloma and noninfiltrating papilloma or carcinoma located in areas difficult to visualize transurethrally. The procedure is also applicable for recurrences and for poor surgical risks with tumors of higher malignancy and some muscular infiltration if not accessible transurethrally.

Partial cystectomy is ideal for primary or recurrent growths, single and nonpapillary, located in the

upper half of the bladder, and capable of being completely removed. Tumors in the diverticula of the bladder may be handled similarly.

Infiltrating carcinomas that are operable and cannot or should not be extirpated by partial cystectomy should be treated by total cystectomy. Noninfiltrating papillary tumors which recur faster than destruction is possible, papillary carcinomas with muscular infiltration, and nonpapillary carcinomas with infiltration involving the basal bladder area that are operable are also removed by total cystectomy if the patient is a suitable surgical risk.

In some instances, when infiltration has occurred through the muscularis, cystectomy is used in conjunction with radical dissection of the perivesical iliac and aortic nodes. Multiple-stage cystectomies are undesirable.

Some method of diverting the urine from the upper part of the urinary tract is used for palliation in inoperable carcinoma of the bladder. Ureterosigmoidostomy is usually the most desirable method.

¶ NEUROGENIC ENURESIS caused by defective cerebral integration or cortical lesions may be palliated by intravenous injections of from 50 to 150 mg. of Banthine four times a day. The substance is useless for psychogenic incontinence. In 40 instances of renal or ureteral colic or bladder pain, Jack Lapides, M.D., and Austin I. Dodson, Jr., M.D., of the University of Michigan, Ann Arbor, report that distress was relieved within three to ten minutes after administration of 100 to 200 mg. of the drug. Even long-term therapy is without lasting benefit in interstitial cystitis. Banthine augments the effectiveness of hydrostatic distention by enlarging the capacity of certain types of spastic bladders.

Arch. Surg. 66:1-9, 1953.

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After ingestion of I^{131} , thyroid abnormalities may be detected by a recording scintillation counter.

Scintigrams of the Thyroid Gland

FRANZ K. BAUER, M.D., WILLIAM E. GOODWIN, M.D.,
THOMAS F. BARRETT, M.D., RAYMOND L. LIBBY, PH.D.,
AND BENEDICT CASSEN, PH.D.

University of California, Los Angeles

THYROID tissue containing radioactive iodine can be visualized by a directional scintillation counter attached to a printing device.

Scintigrams are invaluable in showing toxic or functionless nodules, diffuse glandular enlargement and reduction after treatment, aberrant thyroid tissue, and some types of cancer.

The procedure is described by Franz K. Bauer, M.D., William E. Goodwin, M.D., Thomas F. Barrett, M.D., Raymond L. Libby, Ph.D., and Benedict Cassen, Ph.D.

I^{131} is administered orally by capsule in a dose of 100 to 300 microcuries. Hyperthyroid patients are examined twenty-four hours later and others within forty-eight hours. The subject is immobilized in a comfortable position, and the scanning tube is run over the neck or other suspected area.

The scaling circuit is adjusted so that the printing relay registers at intervals varying from 2 to 64 counts. In case of toxic adenoma, density of the record clearly shows the difference between inert and active tissue (Fig. 1). The shape of a diffusely enlarged gland is reproduced (Fig. 2) and weight of

Scintigrams of the thyroid gland. California Med. 77:380-382, 1952.

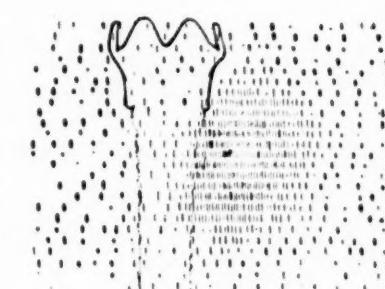


Fig. 1. Toxic thyroid adenoma



Fig. 2. Diffusely enlarged thyroid

the gland is determined by the formula of Allen and Goodwin.

Mediastinal, prelaryngeal, or sublingual masses may be revealed. Approximately 1 thyroid carcinoma in 7 will accumulate radioactive iodine.

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Chronic Fatigue

ROBERT S. SCHWAB, M.D., AND THOMAS DE LORME, M.D.
Massachusetts General Hospital, Boston

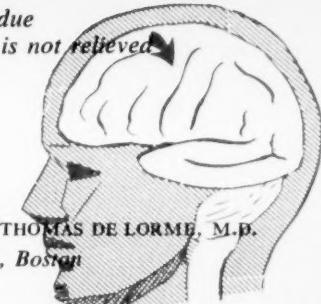
If fatigue is out of proportion to the labor done and does not disappear when work is stopped, the complaint is presumably of psychogenic origin. Measures other than rest are required.

The feeling of tiredness in nervous people is produced by emotional and situational problems and not by physical activity, conclude Robert S. Schwab, M.D., and Thomas DeLorme, M.D., after studying fatigue curves for 65 normal subjects, 50 patients with myasthenia gravis, 25 with Parkinson's disease, 50 with miscellaneous neurologic conditions, and 40 with symptoms of nervousness and fatigue but no structural disease of the muscular or nervous system.

A normal person doing voluntary physical work develops fatigue of the muscles and a concomitant subjective feeling of tiredness. When the desire to continue and the wish to stop work exactly balance, the work ceases. After a few minutes, the man has recovered and can start again.

That part of the brain where volitional action and consciousness arise tires before the conducting pathways and effector organ. Ergograms of voluntary muscle action show a consistent postponement of

Psychiatric findings in fatigue. *Am. J. Psychiat.* 109:621-625, 1953.



muscular fatigue when neostigmine is given to patients with myasthenia gravis. Ergograms of voluntary action of patients with psychiatric fatigue are often in error because of such motivational factors as suggestion and reassurance.

A normal runner who drops with exhaustion after a race can still voluntarily move individual muscles, and these muscles will respond to electrical stimulation. The tendon reflexes are also still active. But, when an individual muscle is fatigued electrically, the subject does not experience any sensation of general fatigue.

The location of the feeling of tiredness, then, is in the brain, and resting the muscles of patients with chronic fatigue of nonneurologic nature is a waste of time. Treatment must correct the psychologic causes of fatigue.

Motivation is always an important factor in fatigue. A normal individual hanging from a horizontal bar tires and lets go after a minute to a minute and a quarter. If strong suggestion and encouragement are used, or hypnosis, the time is prolonged to one and a half minutes. If the subject is offered money to beat previous time, endurance rises to as much as two minutes.

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Medical Forum

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Problems of Office Anesthesia*

QUESTION: Is anesthesia, other than topical and local, advisable for office use?

*Comment invited from
Francis F. Foldes, M.D.
Edward B. Tuohy, M.D.*

►TO THE EDITORS: All types of anesthesias can be performed in the office on patients in good physical condition, provided that:

1] A trained anesthesiologist, capable of taking care of any anesthetic emergency, is present.

2] All equipment and drugs necessary for treatment of emergencies are available.

3] Satisfactory space is available where the patient may recover from the effects of the anesthesia and surgery under supervision.

The management of anesthesia in office practice should not differ from that in hospital practice. The patient to be anesthetized should not have taken any solid foods for eight to twelve hours, or any fluids for three to five hours preceding the anesthesia.

As Dr. Forrest E. Leffingwell has indicated, premedication ought to be given intravenously in appropriate doses to insure rapid onset and the minimal duration of effect.

Whenever possible, local and regional anesthesias with short-acting agents should be used so that the patient may leave the office soon after conclusion of the operation. Epidural anesthesia can also be used satisfactorily for this purpose.

When general anesthesia must be resorted to, preference should be given to short-acting agents such as nitrous oxide, trichlorethylene, cyclopropane, and Vineethene. Pentothal Sodium in combination with nitrous oxide-oxygen and intravenous Demerol will also allow rapid recovery of the patient.

The most frequently encountered complications in office practice anesthesia are: [1] reaction to local anesthetic agents, [2] vomiting with or without aspiration, [3] asphyxia due to aspiration of blood, inadequate airway, laryngeal spasm, bronchospasm, or inadequate gas mixtures, and [4] depression caused by excessive depth of anesthesia.

To prevent reactions, patients should receive a short-acting barbiturate intravenously before the administration of a local anesthetic agent. Epinephrine, 1:200,000 to 1:400,000, should be added to the

(Continued on page 130)

*MODERN MEDICINE, Feb. 1, 1953, p. 114.

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MEDICAL FORUM

local anesthetic agent to slow down absorption. By careful technic, the quantity and concentration of the local agent used for regional procedures can be further decreased. Extra care should be taken with the topical application of potent surface anesthetic agents used in urologic and other endoscopic procedures.

When relaxation is indicated, succinylcholine is the drug of choice in office practice.

A skin wheal test may be used to obviate allergic reaction when allergy is suspected in a patient. If the use of a local anesthetic agent is followed by reaction, attention should be focused on the patient's oxygenation. If respiratory depression occurs, immediate intubation and artificial respiration with oxygen through the endotracheal tube should be done. Should excitement, tremors, or convulsions follow the administration of the local anesthetic agent, short-acting barbiturates should be given cautiously until the excitatory phenomena subside. In this respect, it should be remembered that excitation caused by local anesthetic agents is usually followed by depression.

The best way to avoid vomiting during anesthesia is to empty the patient's stomach, preferably by inducing vomiting before the start of the anesthesia. It is also advisable to insert early, or even before the start of the anesthetic, a cuffed endotracheal tube under topical anesthesia. In some nonintubated patients, vomiting of solid material can lead to disaster even in the presence of an experienced an-

esthetist and all necessary equipment.

Liberal use of an endotracheal tube is the best safeguard against asphyxia in most instances. Anyone who tries to carry out operative procedures under general anesthesia without an endotracheal tube in any part of the respiratory or upper gastrointestinal tract, or on patients in whom the airway is not freely accessible during the operative procedure, is courting disaster. This also applies to dental work done under Pentothal Sodium anesthesia. Cuffed tubes or packing around the tubes should be used when there is danger of aspiration.

If laryngeal spasm occurs, there should be no hesitancy in administering a large dose of succinylcholine, intubating the patient, and administering oxygen through the endotracheal tube by intermittent pressure on the inhalation bag until spontaneous respirations return.

In bronchial spasm, besides endotracheal intubation, small doses of intravenous epinephrine and aminophylline should be used. To obviate bronchospasm, Pentothal Sodium should not be given to patients with allergic histories. Epinephrine, however, should not be employed if the general anesthetic agent is cyclopropane.

The oxygen concentration of the inhaled gas mixture should never be less, and should preferably be more, than 20%. In this respect, not the concentration indicated by the flowmeters of the machine but the actual bag concentration is the decisive factor (*Ann. Surg.* 136: 978-981, 1952).

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MEDICAL FORUM

depth of anesthesia can best be avoided if muscle relaxants and not the general anesthetic agents are relied upon for the production of relaxation, when indicated.

The occasional emergency delirium seen after cyclopropane and less frequently after Pentothal Sodium can be very annoying in office practice. Intravenous use of 25 to 50 mg. of Demerol usually quiets such patients.

Despite the availability of a trained anesthetist and equipment, general anesthesia is not advisable for patients in poor physical condition or with known serious underlying pathology. These patients should be cared for in hospitals where additional help is readily available.

FRANCIS F. FOLDES, M.D.
Pittsburgh

► TO THE EDITORS: Each year it becomes increasingly obvious that general anesthesia in the offices of most physicians and dentists is a dangerous routine procedure.

I am quite firm in my thinking on this matter, because in most instances equipment in these offices is inadequate, and the people involved are not qualified to handle difficult resuscitation problems. I know this treads on a lot of toes—particularly of the dentists—but preventable deaths are occurring all too frequently in situations where "drop stocking" type of work is being done.

Now that anesthesia is so much in the limelight, at least insofar as coverage of malpractice insurance

and the willingness of lawyers to instigate suits are concerned, I feel that every precaution should be taken to protect the doctors and dentists involved and point out that they are taking some very fancy risks and probably do not know what can happen.

EDWARD B. TUOHY, M.D.
La Cañada, Calif.

The Don'ts of Spinal Anesthesia*

► TO THE EDITORS: I agree with Dr. Bruce M. Anderson that, as a general rule, spinal anesthesia should not be given to patients with coronary artery disease, pronounced arteriosclerosis, valvular heart disease, aortitis, or severe hypertension. I don't agree, however, that it should never be given.

Low spinal anesthesia (T 11 or 12) is excellent for operations on the lower extremities or for such procedures as transurethral resection. Patients undergoing the latter operation very often have one or more of the cardiovascular lesions mentioned. Low spinal anesthesia, particularly with the legs in the lithotomy position, disturbs cardiovascular integrity very little.

Spinal anesthesia is excellent for lumbar laminectomy, but general anesthesia can be successfully used.

Should one follow Dr. Anderson's "don'ts" with a little latitude in specific instances, few complications would arise.

MARGARET F. BARCLAY, M.D.
Chicago

*MODERN MEDICINE, July 15, 1952,
p. 113.



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1. Behrman, H. T., Combes, F. C., Bobroff, A., Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

2. Turell, R.: New York St. J. M. 50:2282, 1950.

3. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives Pediat. 68:382, 1951.

MEDICAL FORUM

Pelvimetry and the Contracted Pelvis*

QUESTION: How important is the external conjugate—the Baudelocque diameter—in obstetric examination?

Comment invited from
Abraham M. Lilienfeld, M.D.
Isadore Dyer, M.D.
D. Frank Kaltreider, M.D.
Thomas W. McElin, M.D.
John E. Savage, M.D.
Charles E. McLennan, M.D.

► TO THE EDITORS: I read with great interest the article by Dr. William Schuman on a reduced Baudelocque diameter as an index of contracted pelvis. I think Dr. Schuman's thesis is provocative, particularly today when estimates of the capacity of the pelvis by external mensuration have been abandoned in many of the teaching hospitals.

Dr. Schuman bases his argument on 13 cases in which the Baudelocque is compared with the obstetric conjugate as determined by roentgenogram. He then compares the range and average of the differences between his Baudelocque and roentgenogram with a series of 115 cases that were reported by Dippel in 1939.

From the comparisons he infers that the Baudelocque is a reliable index of the obstetric conjugate when under 18 cm. and unreliable when over 18 cm. The number of cases on which this conclusion is based seems rather small for any conclusion. Is it legitimate to com-

pare a series of measurements made by different individuals and subsequently draw inferences from this comparison?

It would be helpful to consider what type of data would be necessary to determine the suitability of the Baudelocque. One of the basic requirements for any measurement is reproducibility by the same observer at different times and by different observers at the same time. External measurements vary considerably, depending on what end points are used, how much pressure is placed on the soft tissues, and so on. Therefore, demonstration of the Baudelocque as a reproducible measurement is essential.

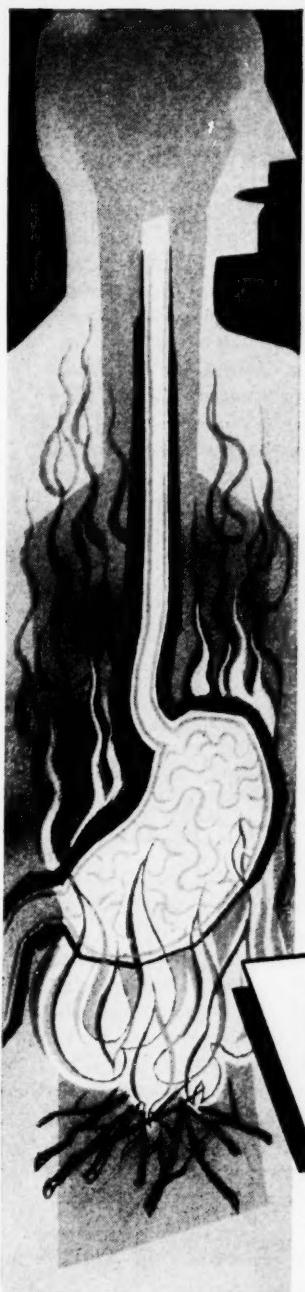
This has already been done for roentgen measurements. After this determination, comparison of the Baudelocque and obstetric conjugate would be necessary in a large series of patients. From this comparison it would then be possible to determine whether this measurement can serve as an index of obstetric conjugate.

Dr. Schuman's statement that roentgen pelvimetry is not infallible is no doubt true; but what diagnostic test in medicine is? All that can be hoped for is that the probability for making a correct diagnosis is increased with the addition of roentgen mensuration to clinical judgment.

A greater number of studies on the evaluation of roentgen pelvimetry as a diagnostic tool are very much needed.

ABRAHAM M. LILIENFELD, M.D.
Baltimore

*MODERN MEDICINE, Jan. 1, 1953,
p. 97.



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MEDICAL FORUM

► TO THE EDITORS: Many factors are to be considered in predelivery appraisal of pelvic capacity. These include the general build and physical structure of the body, anatomic versus chronologic age of the patient, and the bony structure and index of molding of the fetal head.

In considering the female pelvis alone, and in eliminating many of the more complicated anatomic differences often too nebulous to be of value, 3 planes may be studied: the pelvic inlet, midplane, and outlet.

Clinically, the anteroposterior diameter of the inlet can be appraised by vaginal examination. The outlet can be measured with any ordinary pelvimeter with greatest accuracy. The midplane, at which most obstetric difficulties arise, cannot be measured with any degree of accuracy clinically.

Dr. Schuman's report is concerned with one diameter of the inlet, the anteroposterior.

A previous study of 1,000 private patients in evaluating roentgen pelvimetry included 850 primigravidae and 150 multiparas. The norms for obtaining roentgenogram information in primigravidae were: [1] suspect pelvis on office evaluation; [2] suspicion of an unusually large baby, unusual position or presentation; [3] nonengagement of fetal head at thirty-eight weeks; and [4] postmaturity. In multiparas, the standards were: [1] loss of previous baby or babies; [2] previous difficult labor; [3] suspect pelvis in which previous babies had been small or premature; and [4] suspicion of unusually

large baby, unusual position or presentation.

In this group were found 32 inlet contractions, 197 midplane contractions, and 17 outlet contractions. Of the inlet contractions, 11 were in combination with midplane contraction, and all 17 outlet contractions were in combination with midplane contractions. *No outlet contraction existed alone.* The inlet, therefore, contracted in 3.2% of this selected group, was of least importance in incidence.

Conclusions at the time were as follows:

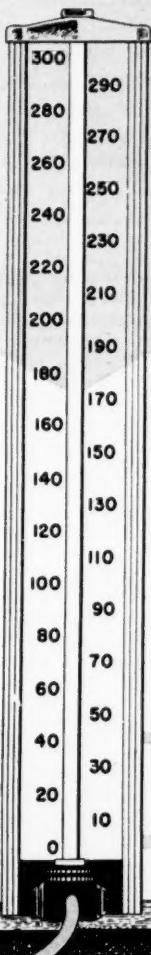
Of the 32 inlet contractions, 11 were of enough magnitude to require delivery by cesarean section. These included 1 breech and 1 brow in primigravidae. In the remaining 9, the presenting part failed to enter the pelvis.

Recognized inlet contraction and/or cephalopelvic disproportion at the inlet in vertex presentations offered no great problem. If serious, elective section was performed. If borderline, a sufficient trial of labor influenced decision. If combined with midplane contracture, the prognosis for vaginal delivery was considered grave.

All marked discrepancies at the inlet were detected clinically by internal measurement.

Other very important considerations of the inlet adequacy lie with additional knowledge of the compensatory transverse diameter, asymmetry, and tilt of the inlet. Since the majority of fetal heads enter the pelvis in the transverse diameter and the average fetal biparietal diameter is 9.5 cm., this transverse accommodation may allow engagement even in borderline flat pelvises. I know of no clinical

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1. Parsonnet, A. E., et al.: J. M. Soc. New Jersey 47:504, 1950.

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MEDICAL FORUM

method of accurately determining these important diameters.

The above views have been substantiated by experience in our share of the 12,000 deliveries a year on the Tulane Service at Charity Hospital. These, with the 3 out-of-town services, provide approximately 9,800 deliveries a year which the department monitors. The over-all cesarean section rate is about 3.5%.

External measurements, other than those of the pelvic outlet, have been discontinued for some time. Although, in defense of Dr. Schuman's presentation, an accurate appraisal of his findings is not available, years of impressions gave no faith in the value of the Baudelocque diameter. It is certain that if we used the measurement of less than 18 cm. as a criterion for roentgen pelvimetry and as an indication of expected trouble, the number of roentgen determinations and the amount of trouble in the southern Negro would be most alarming. This is not the case.

Baudelocque diameters of less than 18 cm. are the rule. The Negro pelvis with degrees of inlet contraction and commonly flat sacrum is so constant that not infrequently the race of the patient can be established correctly by casual view of the pelvograms. We would err seriously if we placed much reliance on an external measurement of one single diameter which belied the true situation of pelvic adequacy, particularly when the other variants are of greater importance in the outcome.

I do not agree that interpretation

of roentgen pelvimetry is difficult and that few are capable of doing it. Every resident masters the technic and, by constant application of roentgenogram versus patient behavior, soon learns to appreciate the limitations as well as value, never lending supreme confidence when interpretation is contrary to the progress of labor. This may be partially borne out by the fact that I know of no instance of craniotomy performed on the combined services since July 1946 with the exception of those on dead hydrocephalic infants.

In appraisal of Dr. Schuman's conclusions:

- We would be willing to retain the Baudelocque diameter as part of the prenatal observation and rely on some fixed figure of adequacy, which would necessitate standards for white and Negro patients, if a large population (5,000 or more) were studied and if, after studying the variants, the value could be unequivocally established in the prognosis for delivery.
- The series is too small to accept the correlation between the Baudelocque diameter and true conjugate.
- I do not believe, on the basis of our experiences, that there is approximately 50% incidence of mechanical complications of labor in patients with a Baudelocque diameter of less than 18 cm. In 1,000 patients, 32 had known inlet contractions of less than 10.5 cm.; only 11, or 34.4%, required cesarean section.
- It may be premature and dogmatic to conclude, in view of the material presented, that an external conjugate of less than 18 cm. "should be considered an obstetrical stigma."
- The pelvimeter should not be considered of historical interest only. It is of extreme value in obtaining measurements of the pelvic outlet, which, if contracted, mirrors midplane bony architecture.

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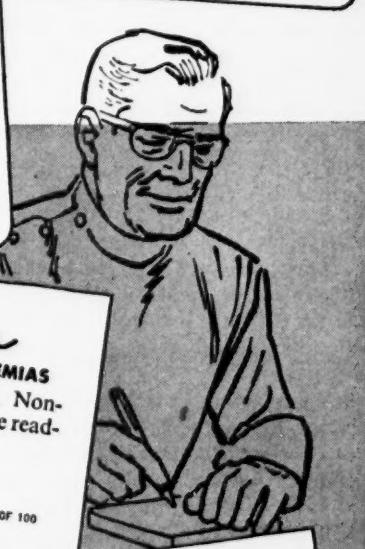
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MEDICAL FORUM

The entire subject is concerned with inlet adequacy. The following management has been satisfactory in the detection and treatment of inlet dystocia:

1] Prenatal pelvic appraisal is determined on the first visit. This is enhanced by adequate obstetric history of past performance.

2] At the eighth month, a careful pelvic survey is again made. The diagonal conjugate is measured internally, the outlet is measured, and the examiner writes down his findings, including height of the fundus, rough estimation of fetal size, and presentation.

3] Roentgenograms are made of all suspect pelvis on admission if the fetal head is not engaged in the primigravida or fails to enter the pelvis on pressure in a multipara or if the baby presents as a breech and is not small.

4] When inlet contraction is established or dystocia due to fetal size is anticipated, a trial of labor is planned with care. If engagement fails to materialize, cesarean section is planned. Just before section and on the operating table the membranes are ruptured. If the head then fails to enter the pelvis, the operation proceeds. If descent occurs, additional trial is offered the patient.

5] When failure of engagement occurs, even in instances of normal pelvis, normal clinical appraisal, and/or previous facile delivery, these patients are completely re-evaluated. Among the many conditions producing inlet dystocia, we have encountered intramural fibroids, genital and extragenital tu-

mors, oversize infants, monstrosities, low placental implantations, subclinical diabetes, nonsymptomatic uterine rupture with the fetal head in the superior strait, cephalic deflection, asynclitism in fat women who have pendulous abdomens, and 1 instance of Paget's disease which in four and one-half years contracted the patient's inlet. In her sixth pregnancy the measured inlet anteroposterior diameter was reduced to 7 cm. In none of the above cases would any external measurement aid the diagnosis or replace the most important clinical examination of every woman who goes into labor.

6] When marked inlet and mid-plane contraction exists, except in the case of an unusually small baby, cesarean section is the procedure of choice and offers the best prognosis for mother and baby.

ISADORE DYER, M.D.
New Orleans

► TO THE EDITORS: Baudelocque's observation in 1781 of a relationship between the external conjugate and the obstetric conjugate was astute. He suggested that one may subtract 3 in., 7.62 cm., from the external conjugate and obtain a reasonable measurement of the true conjugate. As early as 1867 Dohrn questioned the accuracy of subtracting 3 in. and stated that the difference varied. Ehrenfest in 1906 found no relation between the Baudelocque diameter and the obstetric conjugate. Dippel showed by roentgenogram in 1939 that the



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MEDICAL FORUM

range of difference is 4.93 to 13.5 cm. Schuman recognizes this variation and stresses that a short Baudelocque diameter—less than 18 cm.—may give an index to the contracted pelvis.

The anteroposterior shortening of the inlet can be more easily determined by measuring the diagonal conjugate. Smellie recommended this procedure in 1752, thirty years earlier than Baudelocque's recommendation of the external conjugate. Unfortunately, Baudelocque's observation was more highly regarded by most obstetricians until recently.

If one admits that the short external conjugate is a good index of anteroposterior shortening of the inlet, its use cannot diagnose transverse contraction. Arantius, in the middle of the 16th century, recognized the narrow pelvis as a cause of dystocia. Ehrenfest remarked: "Most practitioners (and I do not exclude by this term obstetricians) have formed the opinion that the true conjugate actually is the one diameter which in cases of contracted pelvis decides the outcome of labor. This opinion obviously is erroneous." Steinbrecher in 1907 and Stude in 1932 stressed the importance of the transverse diameter as a diameter to be considered in inlet dystocia. I have also done so (*Am. J. Obst. & Gynec.* 62:163, 1951).

The obstetric conjugate and the transverse diameter can only be measured accurately by roentgenogram. However, the roentgenogram is not all-powerful from the viewpoint of prognosis. It is merely an

accurate method of measurement, a means to prepare the obstetrician for possible dystocia and thus to protect the patient accordingly during labor. Pelvimetry is infallible when used as a yardstick to warn the obstetrician and not as a purely prognostic agent.

My conclusions are that the most accurate method of determining pelvic contraction is the roentgenogram. Why use inferior methods?

At the moment, the roentgenogram is not universally available. Where it is not, I suggest that the diagonal conjugate will be more accurate than the Baudelocque diameter and can be as easily obtained as a screening procedure.

D. FRANK KALTREIDER, M.D.
Baltimore

► TO THE EDITORS: If the Baudelocque diameter is less than 18 cm. in a primigravida or in a multigravida with a history of previous stillbirth, difficult delivery, or small babies, I feel that roentgen pelvimetry should be done. I also believe that if the external conjugate is 18 cm. or less, I will, in most instances, be able to reach the sacral promontory, which in itself calls for roentgen survey.

The function of the external conjugate diameter is almost always fulfilled in the taking of the diagonal conjugate. The external conjugate offers no information that the diagonal conjugate cannot provide more accurately.

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MEDICAL FORUM

► TO THE EDITORS: For the past six years we have eliminated the external measurements of the pelvic inlet in private and clinic practice. This is in agreement with the recommendations of the authors of leading modern textbooks.

We use systematic manual internal pelvimetry together with roentgen pelvimetry in all suspicious cases.

We certainly agree with the statement that roentgen pelvimetry is not infallible, and that the interpretation of films should be made by the obstetrician.

We would like to stress the importance of combined internal clinical examination and roentgen pelvimetry in the management of obstructed labor.

JOHN E. SAVAGE, M.D.

Baltimore

► TO THE EDITORS: Since the obstetric and external conjugate diameters are not in the same plane, and since Dippel (*Surg., Gynec. & Obst.* 68:642, 1939) found that the difference between the two ranged from 4.9 to 13.5 cm. in a group of 115 pelvis studied radiographically, it seems unwise to revive interest in the external conjugate diameter as an indicator of pelvic contraction.

I agree with Dr. Schuman when he implies that an inaccurate or poorly interpreted roentgenogram may engender false security. It also may lead to unnecessary cesarean section. Therefore I am opposed to adding "Baudelocque less than 18 cm." to the well-established list of indications for pelvic radiography.

CHARLES E. MC LENNAN, M.D.

San Francisco

Doctor to Doctor

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Case MM-240

THE CLUE

ATTENDING M.D.: A man of 40 who has had chronic glomerulonephritis for five years had infectious hepatitis seven weeks ago. He was admitted on the third day and has been here ever since. He was gradually improving, and the jaundice diminishing. But today, to my surprise, he began to cough and raise grossly bloody sputum. I hadn't seen him for the last three days and today I detected scattered petechiae on the arms, legs, and abdomen.



The patient tells me that his stool was very dark this morning and he feels quite weak. I have just come from his room and have ordered emergency blood work.

VISITING M.D.: What is the history of the hepatitis?

ATTENDING M.D.: It began with anorexia, lassitude, chills, and fever. The patient had dysuria, then generalized icterus developed. During the next three weeks he became much better. The Chief of Medicine was quite satisfied that it was a case of viral hepatitis; the history and all tests were confirmatory. One

month before the onset his liver had reached about 2 fingerbreadths below the costal margin and was slightly tender. The spleen cannot be felt. Liver biopsy was compatible with the diagnosis.

VISITING M.D.: Putting aside the present acute episode, describe the past treatment.

ATTENDING M.D.: Beginning on the fourth day of hospitalization the patient was given chloramphenicol, 250 mg. three times daily. This was contin-

DIAGNOSTIX

ued until seventeen days ago, when it was withdrawn. He received 1 penicillin injection, of 400,000 units, when the diagnosis was made by the private physician. None since. In the past two weeks he has had a quantity of brewers' yeast, also thiamin chloride, but no other medication. He has been given a diet high in protein, carbohydrate, and vitamins and has been eating very ample amounts of food. We had expected to discharge him next week.

PART II

VISITING M.D.: What about the glomerulonephritis? When and how did it begin and has there been any exacerbation in the present illness?

ATTENDING M.D.: No. It is a classical story. He has a fixed low specific gravity of 1.010 and the urine consistently shows a trace to 1+ albumin, no sugar, and 1+ bile. Blood pressure is 140/100. Eyegrounds normal.

VISITING M.D.: (*Examining patient*) Well, I can add nothing to what you have told me. The man looks anemic. Give me the laboratory findings—only the pertinent ones. (*He thumbs through the voluminous chart.*)

ATTENDING M.D.: Erythrocytes have varied between 4,000,000 and 5,000,000; leukocytes around 6,000. The last count, fourteen days ago, was 6,200 with 68% neutrophils and 32% lymphocytes. The temperature has been normal for three weeks, but today is 100°.

VISITING M.D.: We're going to be powerless to make a confident guess without the laboratory findings, for here is a man with impaired renal and hepatic function in whom purpura suddenly develops. I'd like to have some information about the hepatic functional status.

ATTENDING M.D.: Prothrombin now is 82% of normal, icterus index 22 units—it was 115 at first. The thymol turbidity is 9.5 units. Cephalin flocculation is 2+. Unfortunately, we have not had a blood study for two weeks.

VISITING M.D.: *What?*

ATTENDING M.D.: I'm afraid not; he was getting along so well that someone slipped up on the week's blood study last Monday, and he was due to have another one today. (*A messenger enters and hands him a report.*) Oh, here's the emergency laboratory work.

PART III

ATTENDING M.D.: The white cell count is 2,200 with 43% neutrophils, 54% lymphocytes, and 4% eosinophils. Hemoglobin is 9 gm. per cent and the red count is 3,000,000.

VISITING M.D.: Start a whole blood transfusion as soon as you determine the bleeding time and—

ATTENDING M.D.: (*Interrupting*) It's here: Bleeding time is 5 minutes and clotting time is 12 minutes. No clot retraction in the first hour.

VISITING M.D.: This is ominous. Get the transfusion and a portable chest roentgenogram. It looks to me as if this is probably . . .

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Gunther, M.: Brit. J. Nutrition 6 (No. 2): 215, 1952.

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PART IV

VISITING M.D: (*Continuing*) . . . toxic purpura. I don't know if this could be a complication of infectious hepatitis or not. Since I have never seen it or heard it described, I presume not. So, too, for the glomerulonephritis. An acute episode of this sort would be most remarkable. He was given chloramphenicol. A number of instances of fatal aplastic anemia after administration of this drug have been reported. We'd better get a sternal aspiration.

ATTENDING M.D: (*Next day at bedside*) He had a bad night. Severe melena, epistaxis, gingival bleeding, and more hemoptysis. The chest roentgenograms showed a sort of general clouding. The machine being portable, the films were unsatisfactory for fine interpretations. The radiologist, however, asked me if the clouding could be aspirated blood. Temperature is 103°.

VISITING M.D: The etiology of secondary aplastic anemia is sometimes difficult to prove. In the case of benzol and its derivatives, arsphenamine, irradiation, trinitrotoluene, and a few others, the evidence is conclusive. There are, of course, varying degrees of sensitivity. Why toxic anemia should occur after the drug was discontinued I do not know. Usually agranulocytosis improves with disruption of the therapy. What was the white count today?

ATTENDING M.D: It was 1,200 with 28% neutrophils and 71% lymphocytes; the platelets were too

few to count. Erythrocyte fragility test was normal.

VISITING M.D: The Coombs' test?

ATTENDING M.D: Negative. Bone marrow hypoplastic and no megakaryocytes. We have given him 3 liters of blood.

VISITING M.D: (*Reviewing the chart*)

He had 30 gm. of chloramphenicol during a five-week period . . . certainly a relatively small amount of the drug over a relatively short period of time, considering many of the reported fatal cases. Yet duration of administration is probably not so important as individual idiosyncasy and hypersensitivity. In this case we are deprived of the vital evidence of the blood findings in the two-week period that we are most anxious to know about. It would be easier to understand if we could find a gradual drop before the present fulminating picture.

ATTENDING M.D: I don't think we should condemn a drug which has been effective in so many serious diseases, because of an occasional serious complication.

VISITING M.D: I'm not condemning it, but in my opinion it should be reserved for times when the patient's life is threatened, when other less toxic effective therapy is not available, and when the drug is known to be effective. Self-medication must be prohibited and the patient's blood must be examined at very close intervals of days.

(*Editor's note: The patient expired two days later; autopsy findings were in keeping with the diagnosis.*)

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from Medical Centers

- * COLUMBIA UNIVERSITY, New York City--Changes resembling natural mutations are produced in mice by injection of trypan blue into the mother before and after fertilization. Dr. Max Hamburger found the number of abnormalities greater and more extensive in embryos examined shortly after conception than in mice born at term.
- * UNIVERSITY OF TENNESSEE, Memphis--Injection of ACTH may interfere with natural endocrine activity. When Dr. James D. Hardy gave the hormone to malnourished cancer patients to increase production of cortisone, the pituitary gland stopped secreting ACTH.
- * STATE UNIVERSITY OF IOWA, Iowa City--Cancer of the prostate may be destroyed by radioactive colloidal gold injected with hyaluronidase and epinephrine. The dose is well dispersed in the tumor but healthy tissue is spared because blood vessels contract and rays penetrate only short distances. About half of 160 patients treated by Dr. R. H. Flocks and associates within the past twenty months are still free of symptoms.
- * YALE UNIVERSITY, New Haven, Conn.--Surgical shock may be counteracted by adrenal extracts. If drop in blood pressure is not checked by transfusion and pressor drugs and the eosinophil count is rising, Dr. Mark Hayes injects hormones directly into the blood stream. Cortisone or ACTH may be given several hours before operation to prevent adrenal insufficiency.
- * UNIVERSITY OF ILLINOIS, Chicago--Immunity to transplanted cancer can be produced in one mouse and transferred to another. Lymphatic cancer in susceptible mice was destroyed by roentgen rays. Treated mice were then joined surgically to susceptible subjects, providing continuous cross transfusion. Drs. Arthur Kirschbaum and Nancy Falls report that the vulnerable animal gained ability to eliminate the tumor.

* MEDICAL COLLEGE OF VIRGINIA, Richmond--
Protamine sulfate may protect victims of A-bomb explosions against 2 major hazards, tendency to bleed and susceptibility to infection. A single dose of 45 mg. injected into a rabbit forty-eight hours after roentgen irradiation maintains the blood-clotting mechanism, assert Dr. H. G. Kupfer and associates. Antibodies against injected sheep cells are produced at a higher rate with protamine sulfate therapy than without.

* ST. LOUIS UNIVERSITY--Large size of infants with diabetic mothers may be due to overproduction of growth hormone. After injection of somatotropin into chick embryos on the thirteenth, fifteenth, and seventeenth day of incubation, Dr. Herman T. Blumenthal and associates observed more rapid development as early as twenty-four hours after treatment. Females were affected more than males. Bone growth was particularly stimulated, but protein synthesis apparently increased in all organs.

* JEFFERSON MEDICAL COLLEGE, Philadelphia--
Although healthy liver cells make their own uracil and accept no foreign type, malignant cells absorb a manufactured compound. Chemicals that induce liver cancer in rats apparently combine with uracil in the process; when thiouracil is substituted, neoplasm does not develop. However, Dr. Karl E. Paschkis and associates warn that the drug is too dangerous for prophylaxis against malignant growth.

* ATOMIC ENERGY RESEARCH ESTABLISHMENT, Harwell, England--Neutrons from atomic reactions appear more harmful to male than to female sex organs in mice. Dr. G. J. Neary and associates reduced fertility of male mice 50% by 70 roentgen equivalent physical units given at the rate of 8.3 rep weekly, although growth, body weight, and blood were not injured and no cataracts formed. Twice as large a dose did not appear to affect female fertility. Damaging fission neutrons were obtained when thermal neutrons from the graphite reflector of an atomic pile interacted with uranium on the animal pen floor.

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SHORT REPORTS FROM ABROAD

DENMARK

Metastases in Breast Cancer. Microscopic invasion of the parasternal lymph nodes by metastases of breast cancer necessitates removal of the nodes. Drs. E. Dahl-Iversen and Boerge Soerensen of the University of Copenhagen report that such metastases are relatively common, occurring in 11 of 57 operable cases. The operative approach is best accomplished by the elevation of the second to fourth costal cartilages after the cartilages are cut approximately 1 cm. from the sternal margin. Ligation of the corresponding internal mammary artery may be done if necessary.

ENGLAND

Long-acting Insulin. Dependable twenty-four-hour activity is provided by the new Danish lente insulin. In moderately severe cases, blood sugar can be controlled throughout the day without fear of hypoglycemia during the night, report Drs. R. D. Lawrence and Wilfrid Oakley of King's College Hospital, London. The compound is prepared with acetate buffer, using a suspension of pure insulin and very small quantities of zinc in media at the pH of blood. Semilente and ultra-lente forms, adjusted for twelve- and thirty-six-hour

periods, seem less promising. Lente insulin was compared with soluble, protamine zinc and globin preparations in treatment of 6 men and 5 women with severe diabetes at ages of 25 to 92 years. The new product yielded remarkably constant results and caused no undesirable local or general reactions.

GERMANY

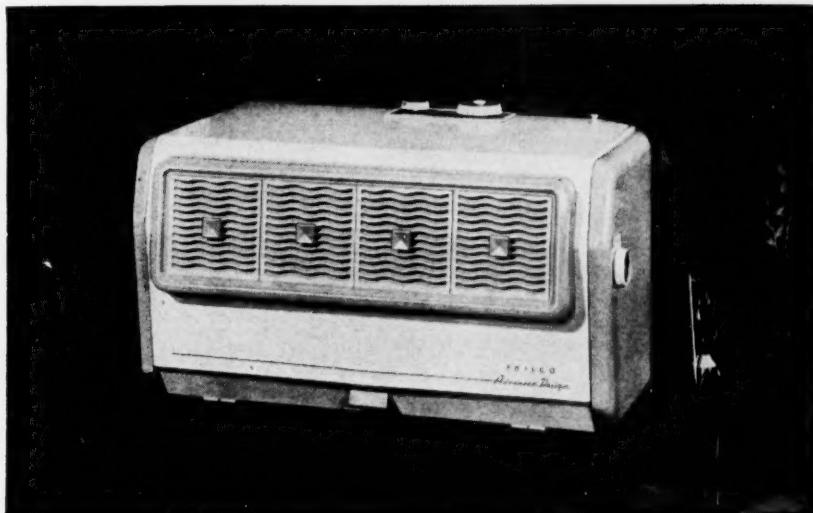
Diagnosis of Infantile Pyuria. In a child, pyuria may be a symptom of genitourinary disease or of an anomaly or may accompany general infectious diseases without renal lesions.

Dr. Helmuth Müller of the Children's Hospital, Bielefeld, lists cystitis, pyelitis, and, sometimes, bacterial nephritis as the most frequent causes of acute pyuria. Onset is accompanied by fever, malaise, chills, and flank pain. Dysuria and even acute retention may occur.

Chronic pyuria is usually the result of congenital anomalies, such as polycystic kidney, hydronephrosis, or tumor, with superimposed infection. The diagnosis can be established by cystoscopic examination and intravenous or retrograde pyelograms. A kidney, ureter, and bladder film or, often, palpation alone helps to make a presumptive diagnosis.

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FROM ABROAD

mides and antibiotics or mandelates are usually effective. When indicated, surgery may offer the best chance for cure.

Pyuria accompanying the acute, general infectious diseases of childhood usually disappears spontaneously upon recovery from the infection unless complications develop.

2

Nonsurgical Treatment of Incontinence. Urinary, and sometimes fecal, incontinence in the elderly woman cannot always be treated surgically. An operation is difficult if the vagina is long and narrow and may even be impossible in some cases, as with ankylosis of the hip joints. Dr. O. Hajek of Bremen uses sclerogenic oily injections to treat incontinence resulting from muscle weakness.

The anterior vaginal wall is exposed by speculum. With a long needle, 1 cc. of the solution is injected on both sides of the sphincter to a depth of 0.5 cm. The vagina is packed tightly to prevent leaking of the solution and to stop minor bleeding, if any. The pack can be removed the next day. For a few days after the injection, the patient usually has a feeling of tension and discomfort in the injected area; micturition may be slightly difficult.

The pain disappears after a week and infiltrations can be felt in the injected area. With correctly performed injections the result is good. If success is not complete, the procedure may be repeated. A similar technic can be used for perianal

injection and even for narrowing of the vagina in case of uterine prolapse, but only when the uterus is small and senile.

3

Isoniazid for Tuberculous Meningitis. Rapid, strong tuberculostatic action and relatively low toxicity make isonicotinic acid hydrazide a promising agent in the treatment of tuberculous meningitis. Drs. A. M. Walter, F. Schmid, and L. Heilmeyer of the University of Freiburg report 8 cases in which isoniazid proved extremely effective; 3 of the patients had been previously unsuccessfully treated with streptomycin and PAS. Prompt improvement of the general condition, return of consciousness, and weight gain were the most striking effects of the isoniazid. In grave cases isoniazid may be injected intrathecally.

4

Proctosigmoidic Roentgen Examination. Outlines of the rectal mucosa may be more easily visualized after insertion of barium-containing suppositories than by use of fluid media. Dr. Karl Frech of University of Mainz adds barium sulfate to rectal suppositories containing bismuth, thymol, hexamethylentetramin, and aluminum acetate. One or more suppositories are inserted after a cleansing enema. The patient is next instructed to walk about for thirty minutes to an hour, because activity promotes an even distribution of the medium over the intestinal wall.

A detailed outline of the mucosa

FROM ABROAD

with all the folds and possible defects can then be obtained and, with proper technic, the lumen as well as the position of the viscus is visible. The suppositories are well tolerated even by children. No inconvenience is noticed in expulsion of the contrast medium.

5

Intracavernous Injections for Pulmonary Tuberculosis. When radical surgery is impossible or inadvisable, repeated intracavernous injections of streptomycin or Conteben are of value in tuberculosis. Drs. Hellmuth Deist and Erwin Lehmann of the Central Clinic, Göppingen, Germany, used such measures to treat 65 tuberculous patients. A total of 3,500 injections were given, twice weekly. Improvement was noticed in over 60% of cases; in 9% the cavities disappeared and the sputa became negative for bacilli. No improvement was seen in 24%, and 7% deteriorated.

The drug is given by transthoracic puncture under fluoroscopic control. The patient lies down for a few hours after the procedure.

Because of the danger of air embolism, bleeding, and empyema, intracavernous puncture is indicated only in severe forms with a poor prognosis, when surgery is impossible because of age, general condition, or extent of lesions. The procedure should never be used in the presence of multiple cavities or infiltrative lesions. Obliteration of the pleural cavity on the treated side is essential before performance of the puncture.

SWITZERLAND

Chronic Hypercalcemia Associated with Congenital Defects. A syndrome consisting of hypercalcemia, osteosclerosis, and nephrocalcinosis associated with congenital malformations is described by Drs. G. Fanconi and P. Girardet of the University of Zürich and Dr. B. Schlesinger and associates of Hospital for Sick Children, London.

Affected children are retarded physically and mentally. Disturbed mineral metabolism is manifested by hypercalcemia, hypercalciuria, osteosclerosis, and nephrocalcinosis. Lowered renal function results in hyperazotemia.

Albuminuria and cylindruria are found; clearance tests for inulin and urea are low. The most frequent anatomic abnormalities are congenital heart disease, pyloric stenosis, and convergent strabismus. Response to symptomatic treatment is poor.

2

Cold Agglutinins in Newborn. Positive reaction to Coombs' test, important in the diagnosis of Rh antibodies in the newborn, may also occur in the presence of incomplete cold agglutinins. Dr. L. Holländer of the Blood Center of the Swiss Red Cross believes the false-positive reaction may result from transplacental transmission of incomplete cold agglutinins. The cold-agglutinin titer of the newborn may be high, especially if the mother had a virus infection during the last half of pregnancy.

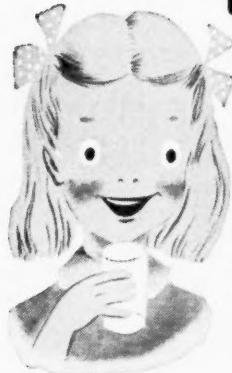
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FROM ABROAD

A false-positive reaction can be detected by repeating the test at temperatures of 37 and 4° C. The reliability of the result can also be checked by the selective absorption technic for the several components of the antiglobulin serum fraction.

3

Steroid Therapy of Menopausal Syndrome. The combined use of androgens and estrogens achieves good effects in treatment of the menopausal syndrome without the disadvantages entailed when only one of the hormones is administered. Drs. H. de Watteville and B. Lunenfeld of the University of Geneva have observed 7 patients given ethinyl estradiol, 0.01 mg. daily, plus methyl androstenediol or methyl testosterone, 25 mg. daily.

Rapid, pronounced improvement of the patient's general condition is followed by reversal of the trophic changes of the vagina. Because of the antagonistic action of the androgens and estrogens upon the endometrium, myometrium, and mammary gland, no pathologic proliferative changes occur. This antagonism decreases the danger for patients previously treated for cancer of the genitalia.

The hormones may be administered parenterally or by linguelets.

ITALY

Vitamin K and Infantile Dysentery. Changes in the intestinal endothelium during infantile dysentery may interfere with absorption of

vitamin K while at the same time intensive antibiotic therapy given for the disorder may reduce the number of intestinal bacteria producing the vitamin. Changes in capillary permeability found in such conditions also suggest a vitamin K deficiency. At Rome University, Dr. F. Mulè administered 10 mg. per kilogram a day of vitamin K orally in conjunction with antibiotics to 80 acutely ill children, all under 4 years of age, who had respiratory and associated intestinal disease and pronounced symptoms of toxicity. These children recovered significantly faster than children given antibiotic therapy alone. Rapid detoxification was noted and the stools return to normal within the first few days. No deaths occurred.

BRAZIL

Therapy for Volkmann's Contracture. Although therapeutic efforts are largely unsuccessful once the symptoms of ischemic contracture appear, the pathologic changes are apparently not truly irreversible for a considerable period. Dr. Arce-lino Bitar of Rio de Janeiro reports 2 patients who had typical contracture, anesthesia, and vasomotor disturbances of the affected arm two months and forty days after an accident, respectively. Both patients were treated with repeated stellate blocks, 1% procaine, once or twice weekly, massage, and physical therapy. Complete restoration of function was achieved in two months.

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BASIC SCIENCE

Briefs

Hematology

Thromboplastin Inhibitor

Human serum and plasma contain a thromboplastin inhibiting factor that acts only in the presence of calcium. Removal of the calcium restores the clotting properties, report Drs. Gerard F. Lanchantin and Arnold G. Ware of the University of Southern California, Los Angeles. The heat-labile, nondialyzable substance can be separated from serum by ammonium sulfate between the levels of 40 and 50% saturation and is stable at room temperature.

J. Clin. Investigation 32:381-389, 1953.

Hematopoiesis

Castle's Intrinsic Factor

Fractionation of the intrinsic factor in human gastric juice is possible by electrophoresis. Concentrated gastric juice is subjected to preparative electrophoresis on filter paper, and several peaks are demonstrated by a protein-staining method. Dr. A. L. Latner and associates of the University of Durham, Newcastle, England, find these peaks to have vitamin B₁₂-binding activity. Material from the peaks of both the cathode and anode sides is active in the same manner as the intrinsic factor. Administration of these fractions of gastric juice with 50-μg. doses of vitamin B₁₂ alters hematopoiesis in pernicious anemia, indicative of

intrinsic factor presence. The material corresponding to the anode peak appears to be the most potent fraction and contains either a mucoprotein or a mucopolysaccharide. Since Castle's factor is heat labile and readily inactivated by chemical procedures, the method of electrophoresis is particularly valuable in discovering the nature of this agent.

Brit. M. J. 4808:467-473, 1953.

Experimental Medicine

Hesperidin and Fertilization

Ovulation, implantation, and normal development of rat and rabbit embryos are not affected by the oral or intraperitoneal administration of phosphorylated hesperidin. Introduction of the hyaluronidase inhibitor into the fallopian tubes of rabbits at the time of sperm penetration also fails to inhibit fertilization, report Drs. M. C. Chang and G. Pincus of Boston University. The fertilizing capacity of rabbit sperm appears to be inhibited to a slight extent when suspended in a 1% solution of the chemical. However, this effective in vitro dose has no in vivo influence. Histologic studies indicate that phosphorylated hesperidin greatly delays follicular cell dispersal, but such dispersal is not a prerequisite of sperm penetration into the eggs.

Science 117:274-276, 1953.

short REPORTS

Hepatology

Liver Regeneration

Partial regeneration of hepatic tissue after 70% hepatectomy is possible in dogs with portacaval transpositions. The inferior vena cava and portal vein anastomoses divert portal blood flow and still provide the liver with a profuse supply of systemic venous blood. Dr. Charles G. Child III and associates of New York Hospital and Cornell University, New York City, report considerable liver regrowth in 8 animals after operation. The data discount the importance of a portal blood factor in liver regeneration and support the concept that failure of regeneration in animals with Eck fistulas is due in part to lack of venous blood flow.

Proc. Soc. Exper. Biol. & Med. 82:283-285, 1953.

Physiology

Methods of Revivification

The critical need in resuscitation of dogs is oxygen to the lungs before circulation fails, regardless of the means of administration. By the use of systolic blood pressure readings in dogs made anoxic by nitrogen, Dr. H. G. Swann and associates of the University of Texas, Galveston, determine the threshold of death in the animals to be approximately 85 mm. of mercury. Attempts to

revive animals are instituted when the blood pressure is at this low level. Insufflation of 5% carbon dioxide in oxygen, or even 2% oxygen in nitrogen, by means of a positive and negative pressure respirator pump or a suck-and-blow pump is found to be equally effective in reviving animals. However, manual artificial respiration and the Eve tiltboard method rarely aid animals at comparable stages in the death process.

J. Applied Physiol. 5:421-428, 1953.

Hemorrhage

Blood Transfusions

Replacing lost blood volume in cases of severe hemorrhage in dogs does not prolong the bleeding of an open artery, and the increased blood volume does not dislodge a clot already formed in the injured vessel, report Drs. Henry W. Mayo, Jr., and Louie B. Jenkins of the Medical College of South Carolina, Charleston. Severance of the superficial femoral artery, comparable in size to the human left gastric artery, was performed on dogs while blood pressure readings were recorded and clotting times observed. Reinfusion of the animals' blood was begun after clots were formed or just after the vessels were severed.

Arch. Surg. 66:137-142, 1953.

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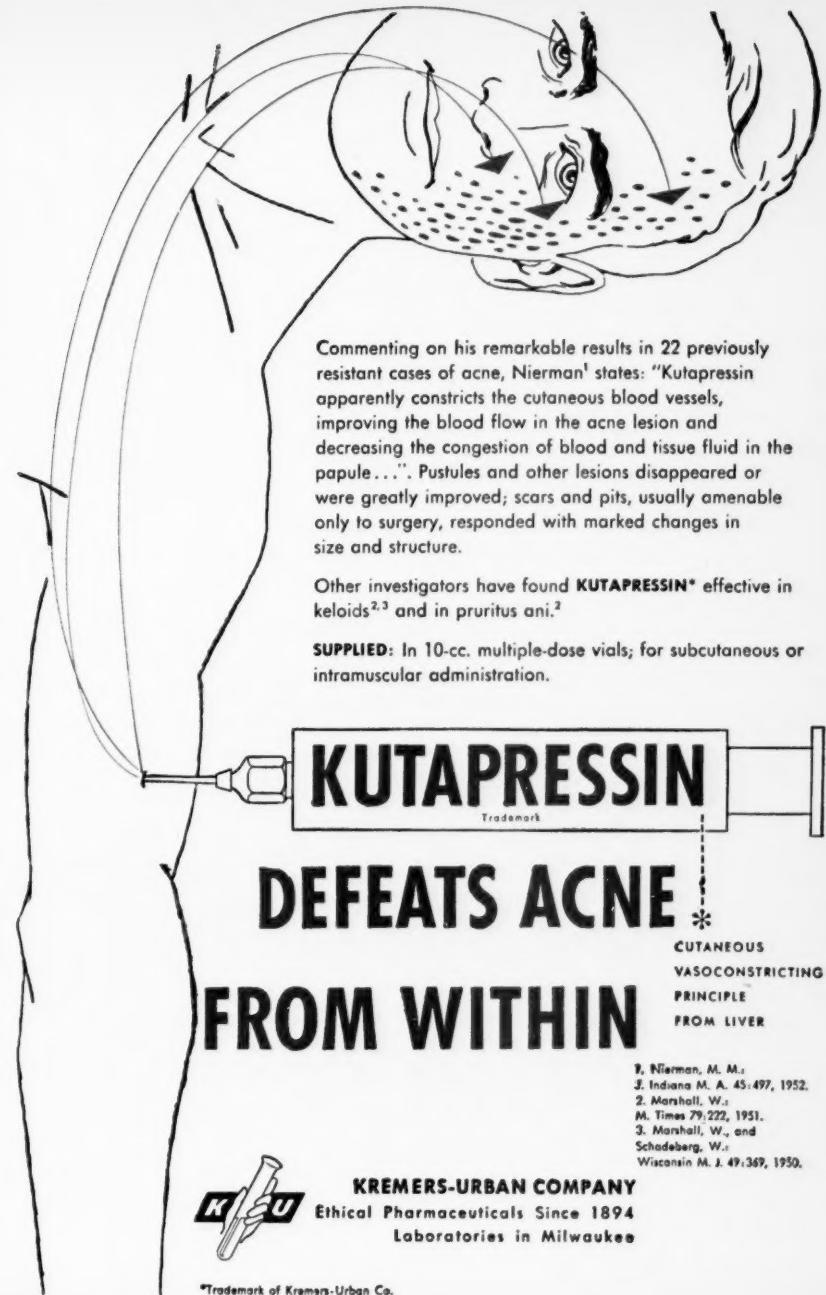
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1. Nierman, M. M.
J. Indiana M. A. 45:497, 1952.
2. Manhoff, W.;
M. Times 79:222, 1951.
3. Manhoff, W., and
Schedberg, W.;
Wisconsin M. J. 49:389, 1950.



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SHORT REPORTS

Pediatrics

Hypothyroidism in Children

The effect of thyrotropic hormone, measured by I^{131} uptake, affords a method for differentiating primary from secondary hypothyroidism in children. Drs. Donald E. Pickering and Earl R. Miller of the University of California, San Francisco, administer thyrotropic hormone for forty-eight hours before injection of I^{131} . Determination of the twenty-four-hour thyroid uptake of the radioactive iodine reveals that children with primary end-organ deficiency show no or only slight change in I^{131} uptake. In contrast, cases which demonstrate collateral signs of pituitary insufficiency, indicating secondary hypothyroidism, respond to thyrotropic therapy, which results in an increase in I^{131} uptake from 35 to 38% over previously determined readings.

Am. J. Dis. Child. 85:135-140, 1953.

Epilepsy

Anticonvulsant Medication

Milontin is effective in reducing the duration and severity of petit mal seizures. Dr. J. G. Millichap of St. Bartholomew's Hospital, London, reports that complete control is obtained in 26% of cases and attacks are reduced by 80% or more in 37% of cases. The most effective daily dosage is related to age and varies from 0.9 gm. for children of 1 to 3 years of age, to 2.1 gm. for adults. Action of milontin (N-methyl-a-phenyl-succinimide) begins within half an hour

and lasts about four hours. Cumulative effect is not observed. Exacerbation of seizures occasionally occurs on withdrawal. The drug is excreted in part in the urine as a glycuronide. Transient side effects such as nausea, vomiting, fever, and rash may occur with small doses at the start of medication. Drowsiness apparently will develop only in children and depends on dosage. Glomerulotubular kidney damage, usually transitory, is observed in about half the cases. Regular and frequent examination of the urine and blood is important during treatment.

Lancet 263:907-910, 1952.

Cancer

Lung Carcinogenesis

Occupations involving exposure to metal fumes and particles seem to be associated with lung carcinoma. Results of interviews with a group of 408 patients with lung cancers were statistically compared to a group composed of the same number of patients with no chest disease or cancer. The groups were equated as to age, sex, race, and the socioeconomic status. Welders, cranemen, and derrickmen exposed to metals, firemen working with boilers, metal miners, and drillers and tool dressers in oil drilling operations appeared more frequently in the series of cancer cases than in the other series, reports Dr. Lester Breslow. Each patient was questioned on smoking habits; data obtained associated excessive smoking with the cancer group.

Pub. Health Rep. 68:286-288, 1953.



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SHORT REPORTS

Toxicology

Therapy of Lead Poisoning

Kidney excretion of lead is promoted by oral or intravenous administration of an organic chelating agent, disodium calcium ethylene diamine tetra-acetate (CaEDTA). Slow intravenous infusion for one hour of 1 gm. on the first day and 2 gm. for four days is used by Dr. J. B. Sidbury, Jr., of the U. S. Public Health Service, Atlanta, and associates in the treatment of plumbism. Oral administration of 30 mg. per kilogram of body weight twice daily for five days is less effective and attainment of maximal excretion is slower than with the intravenous route. All of 7 treated patients improved rapidly, and toxic effects were slight. CaEDTA is stable, odorless, and water soluble and forms a non-ionizing complex with lead which is rapidly excreted in the urine.

Proc. Soc. Exper. Biol. & Med. 82:226-228, 1953.

Antibiotics

Preeclamptic Toxemia

Satisfactory control of severe preeclampsia and eclampsia of late pregnancy is possible with large doses of penicillin or terramycin. However, fetal salvage is not improved. Prompt diuresis, rapid reduction in albuminuria, relief of the subjective symptoms, and some lowering of blood pressure occur when the antibiotics are given, report Dr. George V. Smith and associates of Harvard University and Boston Lying-In Hospital, Boston, and the Free Hospital for Women,

Brookline, Mass. For maintenance therapy, oral penicillin alone is inadequate, whereas 2 gm. of oral terramycin daily will effectively control the syndrome. The advantages of oral terramycin are offset, however, by frequent untoward effects such as diarrhea, vomiting, and fungous vaginitis. Alternate use of penicillin and terramycin supplemented by stilbestrol, to prevent hormonal deficiency, may control toxic manifestations of pregnancy and result in decreased fetal mortality, especially if treatment is instituted at the earliest signs of toxemia.

Obst. & Gynec. 1:302-312, 1953.

Dermatology

Seborrhea and Hormones

Hyperplasia of sebaceous glands results in rats after daily administration of 1 mg. of testosterone propionate for thirty days or 10 mg. of progesterone for fifteen days. Dorsal skin biopsies of treated animals reveal extended enlargement in the glands comparable to the condition seen in acne vulgaris of adolescence. Dr. David Haskin and associates of the University of Chicago suggest that acne in young girls is due to increased elaboration of progesterone. Cortisone induces slight sebaceous gland atrophy in rats, indicating that acneiform eruptions in patients treated with cortisone may lack a seborrheic component. Injections of ACTH produce only slight increases in gland size, probably due to stimulation of adrenal androgen.

J. Invest. Dermat. 20:207-212, 1953.



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INCORPORATED

Crampton, C. W., The Merck Report, 57:26 (1948)
Kimbler, S. T., and Steiglitz, E. J., Geriatric 7:20 (1952)

SHORT REPORTS

Virology

Poliomyelitis Antibodies

Oral administration of living Lansing strain poliomyelitis virus to human subjects who do not have antibodies against the virus can result in specific antibody rise without causing illness. Of 61 nonimmune, mentally defective children fed the virus, none showed any untoward effects from ingestion, report Dr. Hilary Koprowski and associates of the New York State Department of Mental Hygiene, Thiells, N.Y. Viremia was absent in all cases. The virus was isolated from the stools of 29 of the subjects on the fifth to twentieth day after ingestion. Antibody rise in 52 instances was significant enough to consider the immunologic response adequate. Proc. Soc. Exper. Biol. & Med. 82:277-280, 1953.

Gastroenterology

Factors in Peritonitis

Simple physical factors regulate the direction and rate of the intraperitoneal spread of foreign material. Roentgenographic study of the distribution of fluids and particles in the abdominal cavity is possible after introduction of radiopaque liquid mixtures designed to simulate intestinal and gangrenous appendical contents and urine. Drs. Hans H. Zinsser and Arthur W. Pryde of the University of Pennsylvania, Philadelphia, find that such substances spread in dogs more rapidly when viscosity is low and move under the influence of gravity according to the density difference between the opaque me-

dium and the peritoneal exudate. Bacteria extend faster than any of the iodochloral, Thorotrast, or Lipiodol combinations injected. Invasion of viable tissues by appendical flora is slow and independent of previous peritoneal irritation. This process, together with the subsequent explosive bacteremia, can be reduced by an excess of fibrinogen or thromboplastin and is increased in animals given heparin or dicumarol. Fibrin foam is ineffective. Ann. Surg. 136:818-827, 1952.

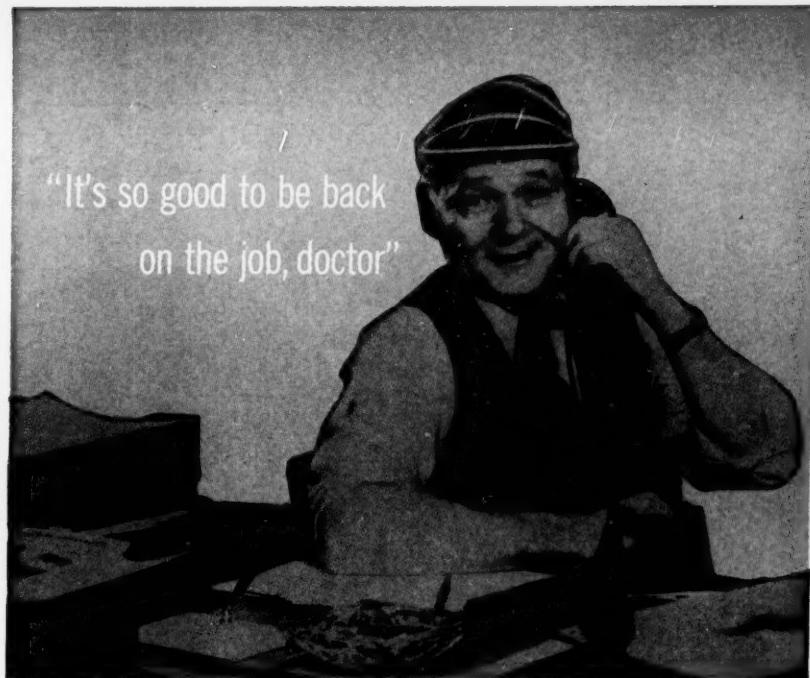
Oncology

Synchrotron Rays for Brain Tumor

High-energy irradiation of malignant tumor has the advantages of deep penetration and relatively little surface absorption. At the Royal Cancer Hospital, London, the electron-synchrotron was utilized, chiefly with roentgen rays of 24,000,000 volts, in 10 cases of cerebral glioma, the majority being astrocytomas of grades I and II. A small, fixed horizontal beam was produced with low output of 5 r per minute at 1 meter and maximal dosage at a depth of 3.5 cm. A total of 7,000 r was given in seven weeks in daily periods of an hour or more. Early palliation was more successful than with other methods, declare Dr. D. A. Layne and associates. Symptoms were relieved and no general reaction or surface scarring resulted. Up to two and a half years after the first treatment, 9 patients are alive, several well and working.

Lancet 264:516-519, 1953.

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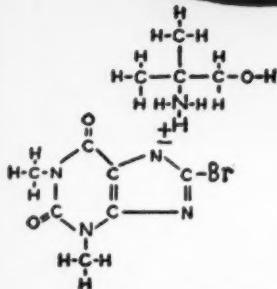
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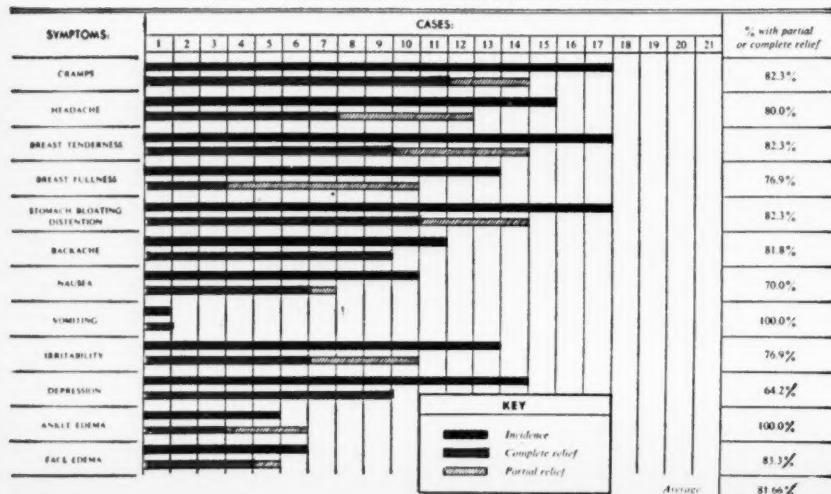
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Vainder* has recently reported that M-Minus 5 gave 81.66 percent relief in a study of 42 women with pronounced symptoms of premenstrual and menstrual distress (see chart). M-Minus 5 was equally reliable in controlling physical and mental complaints. In the great majority of cases, symptoms disappeared completely. The accompanying chart shows the symptoms usually most annoying to the patient—cramps, headache, breast tenderness and stomach bloating—were the ones that responded best to M-Minus 5.

M-Minus 5 affords more than mere symptomatic relief. Acting directly upon the factors which cause abnormal water retention, it promptly relieves the debilitating symptoms of the premenstrual period. In this same manner, M-Minus 5 prevents abnormal uterine and adnexal engorgement which often produces painful dysmenorrhea.

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*Vainder, M.: Ind. Med., Vol. 22, No. 4 (April) 1953.

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Antibiot. & Chemother. 3:117-121, 1953.

Cytology

Radiation Sensitivity

An index to the effect of radiation for cervical cancers is afforded by cytologic studies of the basal cells in vaginal smears before treatment. Cellular alterations of vacuolization, granulation, and augmented cytoplasmic density in the non-malignant basal cells indicate the degree of sensitivity to ionizing radiation, report Ruth M. Graham and Dr. John Barkley Graham. Vaginal smears from cervical cancer patients studied at Vincent Memorial Hospital, Boston, revealed such cellular changes to be associated with a radiation cure rate of 66%, whereas absence of the cytologic phenomenon was associated with a cure rate of only 18%. Vaginal smear studies, particularly in grade II and III cervical cancers, may provide a valuable prognostic index and guide to proper therapy as soon as diagnosis is established.

Cancer 6:215-223, 1953.



hypothyroidism: positive or negative?

No simple "yes" or "no" diagnosis is possible in many suspected hypothyroids. Current literature stresses that a puzzling sterility, annoying obesity, or refractory menstrual disorder is more often the expression of hypothyroidism than is classic myxedema.

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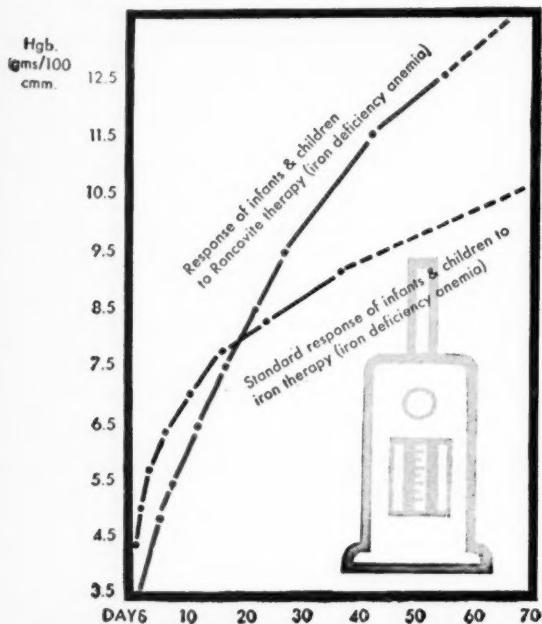
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Comparison of the response of hypochromic anemic infants and children to Roncovite and to iron; with Roncovite, iron utilization was so efficient that 58% of the ingested iron was converted to hemoglobin²—as compared to the usual average of 15% utilization from ferrous sulfate.—

Standard response chart Josephs, H.: J. Pediat. 49:246 (1931).

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Supplied in bottles of 100 tablets.

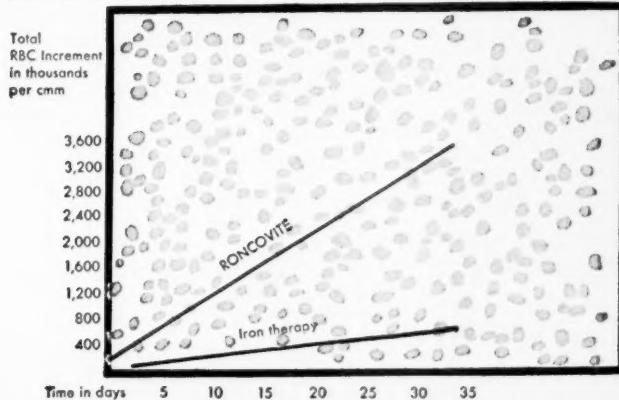
Drops—each 0.6 cc. contains:

Cobalt chloride (Cobalt...9.9 mg.).....40 mg.
Ferrous sulfate (Iron...15.1 mg.).....75 mg.
Average dose—0.6 cc. (10 minims) diluted with water, milk, fruit
or vegetable juice once daily to infants and children.

Supplied in bottles of 15 cc. with calibrated dropper.

- 1: Wolff, H.: Med. Monatsschr. 5:239 (1951); (2) Rohn, R.J., and Bond, W.H.: to be published; (3) Berk, W., et al: New England J.M. 240:754 (May) 1949; (4) Robinson, J.C., et al: New England J.M. 240:749 (May) 1949; (5) Weissbecker, W., and Maurer, R.: Klin. Woch. 24:855 (1947); (6) Wolff, H., and Barthel S.: Munch. M. Wschr. 93:467 (1951); (7) Gardner, F.H.: J. Lab. & Clin. M. 41:56 (Jan.) 1953.

*The pioneer cobalt product.



Comparison of the average erythrocyte response of iron-deficiency anemic children to Roncovite² and to iron therapy.—Computation—Method of Schioldt: Am. J. Med. Sci. 193:313 (1937).

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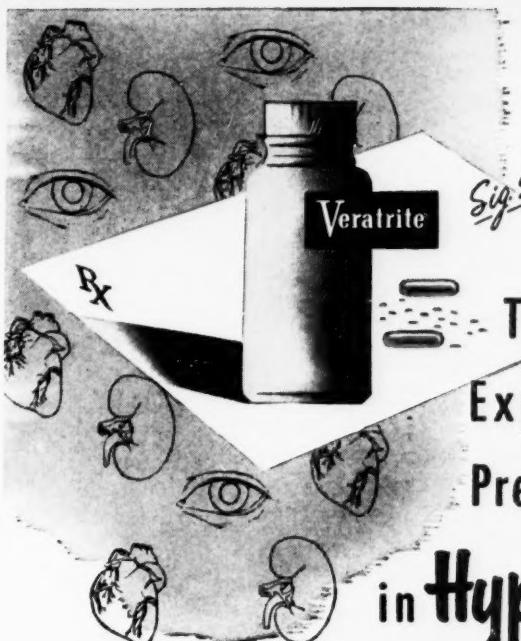
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References:

1. Slinger, W. N., and Hubbard, D. M. (1951), Arch. Dermat. & Syph., 64:41, July.
2. Sleyyan, A. H. (1952), Ibid., 65:228, February.
3. Ruch, D. M. (1951), Communication to Abbott Laboratories.

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Medicine

PROGRESS IN FUNDAMENTAL MEDICINE, 1952 edited by Joseph F. A. Manus. 316 pp., ill. Lea & Febiger, Philadelphia. \$9

MEDICAL ANNUAL 1952: A YEAR BOOK OF TREATMENT AND PRACTITIONERS' INDEX edited by Sir Henry Tidy and A. Rendle Short. 476 pp., ill. John Wright & Sons, Bristol, England. 27s. 6d.; J. B. Lippincott Co., Philadelphia. \$7

DISEASES OF THE ESOPHAGUS by Philip Thorek. 140 pp., ill. J. B. Lippincott Co., Philadelphia. \$10

Electrocardiography

INTRODUCTION TO THE INTERPRETATION OF THE ELECTROCARDIOGRAM by Louis N. Katz et al. 77 pp., ill. University of Chicago Press, Chicago. \$2.50

Cancer

CANCER: NEW APPROACHES, NEW HOPE by Boris Sokoloff. 243 pp. Devin-Adair Co., New York City. \$3.75

CHEMICAL INDUCTION OF CANCER by George Wolf. 250 pp., ill. Harvard University Press, Cambridge, Mass. \$3.50

Ophthalmology

SURGERY OF THE EYE by Meyer Wiener and Harold G. Scheie. 449 pp., ill. Grune & Stratton, New York City. \$15

Surgery

REGENERATION AND WOUND-HEALING by A. E. Needham. 152 pp., ill. Methuen & Co., London. 8s. 6d.; John Wiley & Sons, New York City. \$1.75

DER DARMVERSCHLUSS UND SONSTIGE WEGSTÖRUNGEN DES DARMES by R. Stich. 188 pp., ill. Walter de Gruyter, Berlin. 16.80 DM.

Gynecology & Obstetrics

DIE FRÜHDIAGNOSE DES UTERUSCARCINOMS by Hans Limburg. 2d ed. 208 pp., ill. Georg Thieme, Stuttgart. 19.50 M.

GYNECOLOGY, VOL. I, DISEASE AND MINOR SURGERY edited by Robert J. Lowrie. 852 pp., ill. Charles C Thomas, Springfield, Ill. \$22.50

CLINICAL OBSTETRICS edited by Clifford B. Lull and Robert A. Kimbrough. 732 pp., ill. J. B. Lippincott Co., Philadelphia. \$10

Dermatology & Syphilology

DISEASES OF THE SKIN: A MANUAL FOR STUDENTS AND PRACTITIONERS by Robert M. B. MacKenna. 5th ed. 611 pp., ill. Baillière, Tindall & Cox, London. 42s.; Williams & Wilkins Co., Baltimore. \$8

Neurology

LEHRBUCH DER NERVENKHEITEN IN 30 VORLESUNGEN by H. C. Robert Bing. 818 pp., ill. Benno Schwabe & Co., Basel. 60 Sw. fr.

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PATTERNS OF PSYCHOSEXUAL INFANTILISM by Wilhelm Stekel; edited by Emil A. Gutheil. 412 pp. Liveright Publishing Corp., New York City. \$5

PSYCHIATRIE HEUTE by Kurt Schneider. 32 pp. Georg Thieme, Stuttgart. 2.85 M.

Blood

B-VITAMINS FOR BLOOD FORMATION by Thomas H. Jukes. 125 pp., ill. Charles C Thomas, Springfield, Ill. \$4

YOUR BLOOD AND YOU by Sara R. Riedman. 130 pp., ill. Henry Schuman, New York City. \$2.50

THE RHESUS FACTOR by G. Fulton Roberts. 3d ed. 90 pp., ill. William Heinemann Medical Books, London. 5s.

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FUNCTIONAL NEUROANATOMY by Wendell J. S. Krieg. 2d ed. 659 pp., ill. Blakiston Co., New York City. \$9

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ALCOHOL EDUCATION: A GUIDE-BOOK FOR TEACHERS by Joseph Hirsh and Selma G. Hirsh. 107 pp. Henry Schuman, New York City. \$2.50

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TUBERCULOSIS by Saul Solomon. 310 pp. Coward-McCann Co., New York City. \$3.50

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Gloss, N. L. and Rosenblum, G. J. Clin. Endocrinol. 49:1 (Feb., 1969).

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Upon arriving at the home of one of my patients, I met little Johnny in the yard.

"We're going to have a boy baby today," said the little chap.

"A boy baby?" I said. "How do you know it will be a boy baby?"

"Last year when Maw was sick we had a girl baby," he explained, "and now Paw is sick." —F.M.S.

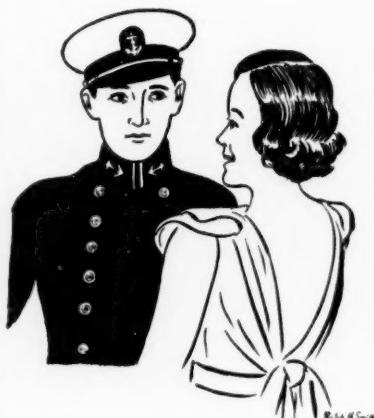
"If your snoring wakes you up," said the absent-minded doctor, "why don't you sleep in another room?" —B.P.S.

Specific Medication

Every so often a patient comes along whose vague description of her symptoms calls for the patience of Job on the doctor's part. Such a lady came in the other day.

"Doctor," she said, "I can't say why, but I get a sort of pain, I don't know where, but it leaves me in a kind of, well, I don't know what."

"Yes," I said, trying to keep a straight face. "In that case, I'll have to give you a prescription for I don't know what. Take I don't know how much for I don't know how many times, and you'll feel better, I don't know when." —A.S.



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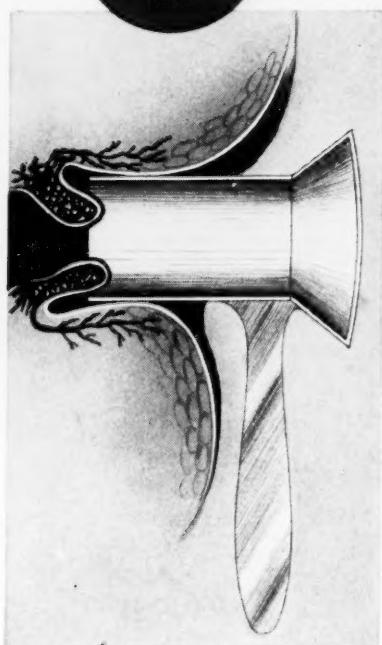
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